Laventhol & Horwath

RETIREMENT HOUSING INDUSTRY 1989

Health Care
Lifecare Community
Continuing Care
Retirement Community
Assisted Living/
Personal Care Facility
Independent Living Units
Adult Congregate
Living Facility
Senior Living Facility
Retirement Community
Real Estate

RETIREMENT HOUSING INDUSTRY 1989

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Health Care and Real Estate
Advisory Services

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Photographer: John McLeod

Mercy is like the scrappy little fighter, who starts with less, but wins through perseverance. The facility wasn't endowed with a beautiful piece of land—it sits on 3.7 acres in inner-city Oakland. Residents live in a six-story high rise, with no kitchens and not much public space. Most of Mercy's population is low-to mid-income, so there are no large entrance or monthly fees to support the facility. Yet, Mercy provides a high standard of living for its 200 residents.

Administrator Else Kiefer attributes Mercy's success to its programs and services designed to enhance each resident's individual dignity, and the facility's caring atmosphere.

A major enhancement was adding nursing care in 1984. Kiefer

knew how terrified residents were of becoming sick and leaving. "It was the saddest thing," she said, describing the residents' fear of moving. "People should finish their life cycle with us."

The 59-bed nursing facility has atriums filled with plants, living rooms with fireplaces and patios. Glass encloses part of the facility, allowing residents the serenity of looking at greenery, yet the security of being enclosed in this busy neighborhood. To serve the lower- to middle-income population, the Sisters of Mercy realized the need to minimize cost. Sandy Barker, project architect, said this was accomplished by using a one-story stucco design—multiple story requires steel or metal—designing double rooms and using the buildings' form, such as sloped ceilings and trellises, to create setting, rather than using fancy finishes.

Kiefer believes that individuals requiring different levels of care are more comfortable living with others of similar abilities; however, the frail and independent elderly should have times to interact. Hence, Mercy's buildings connect, providing easy access and all residents share gardens and recreation areas, as well as social activities.

Mercy's community outreach programs not only extend the community's caring environment to its low-income neighbors, but also enhance the self-esteem of elderly residents who serve as volunteers. Each week, Mercy distributes 550 bags of food to low-income individuals; three times a week, 30 low-income neighbors are served hot lunches; residents join with elderly from the community in recreational activities. And neighbors are permitted to use Mercy's land to till corn and beans.

Mercy draws residents from a wide radius and maintains a long waiting list. That's a testament to its strength, considering its location. This facility carries on the tradition of providing quality care and an appealing life-style for the elderly at a low cost.

WILL THE RISK BE TOO GREAT?

by Joan DiMarco, Lance Malkind and Patricia Greenberg

As of March 1990, the American Institute of Certified Public Accountants may change the way continuing care retirement communities look at the future.

Then, this governing board of the accounting profession will recommend that facilities offering lifecare more accurately predict future health care costs of their residents. The Institute is expected to issue a statement of position that binds all CCRCs to include in their financial statements an actuarial analysis of their health care liabilities.

This analysis will allow CCRCs to gauge more accurately the life span of their residents and thus, the probability of transfer to a nursing care facility at different ages. The longer an individual survives, the chances increase that he will utilize the nursing care facility. Once an individual enters the nursing care facility and the longer he lives, the greater cost of providing care and the greater financial burden on the CCRC.

CCRCs Undertake Risk

The basic premise of a continuing care retirement community is that the facility will offer residents the security that their health care needs will be taken care of until they die. In exchange, residents pay entrance and monthly fees. This provides a satisfying arrangement for both, as an increasing number of seniors desire health care in their retirement facilities. For this system to work, however, CCRCs must ensure that their funding covers the cost of providing health care for its residents.

Agreeing to cover future health care utilization for a specific fee always means risk. Because of uncertainties, it's impossible to predict with 100 percent confidence what benefits will be required. Those who usually provide health care benefits through individual and group medical insurance have devised ways to deal with this risk.

Fluctuations and uncertainties in group health insurance mean that small employers frequently cannot withstand the risk of enormous utilization of health care by their employees. Therefore, they are likely to transfer that risk to a health insurance company. Although large employers may self-insure their health coverage, that is, pay for the medical claims of employees themselves, they will frequently purchase a "stop-loss" policy from a reinsurance company to cover enormous medical claims.

A CCRC is in a similar position as an insurance company that provides benefits for a set premium, or an employer that provides self-funded benefits. The CCRC assumes a considerable level of risk.

Of course, CCRCs have always attempted to manage the risk by estimating the number of residents that will require nursing care in the future. To obtain this forecast, CCRCs have traditionally performed a one-time estimate based on an "average age" of residents and then determined benefits.

This estimate, however, is inaccurate as it fails to recognize fully future costs. A facility's population may include individuals with ages ranging from early 60s to early 90s. The number of years these individuals will live and the health care benefits they will utilize, will vary greatly. For CCRCs to fund adequately future health care costs, they need more accurate representation of their population's life span. These inadequacies prompted the AICPA to recommend actuarial analysis.

Performing an Actuarial Analysis

For a CCRC interested in actuarial analysis, the first step is to hire an actuary skilled in health care issues, particularly one with experience in lifecare. CCRCs present an actuary with a unique situation, and he should possess the understanding and experience to interpret meaningful data.

The actuary assigns individual life expectancies and probabilities of transfer based on the age of each individual at entrance.

For the analysis, the actuary develops a population model. Beginning with the community's census (residents' age, sex and joint or single occupancy status) he uses decrement tables to establish probabilities of death or transfer to the nursing facility at different ages and to forecast the number of individuals in independent living units and the nursing care facility in future years.

The tables, based on published mortality tables, are adjusted to approximate the mortality and morbidity (probability of illness requiring transfer to a nursing facility) unique to CCRC residents. The tables indicate that mortality among independent living unit residents is lower than the entire population while for the nursing care facility residents, it is several times higher. Of course, facilities with a known population (in contrast to an unknown population for a facility at the development stage) would use decrement tables that parallel their own mortality and morbidity experience.

The actuarial model will thus provide a more realistic estimate of the remaining liability and the number of years over which income and expenses must be amortized.

An actuarial model should also provide answers to the following:

- What is the probability that morbidity (or mortality or any other factor) will vary from the expected norm by a given amount?
- What will the effect be on the financial forecast if such a variance occurs?

In particular, higher than expected morbidity and/or lower than expected mortality can drive health care costs above anticipated levels. Hence, sensitivity testing, i.e., testing results to see how sensitive they are in assumptions, should be employed.

The population forecast also allows the following to be estimated:

- Present value of future nursing care costs for the community
- Present value of future fees to be collected for nursing care costs
- Number of individuals expected to need nursing care
- Turnover of units
- Turnover of health care beds
- Number of health care beds required

With this information the adequacy of the health care reserves and entrance and monthly fees can be determined.

Although the AICPA does not recommend how often this analysis should be updated, we suggest every three to five years. However, if a major change occurs in the system, such as adding assisted living or a major variation in resident ages, it should be performed more frequently. New York State may require a yearly analysis, though the legislature has not yet passed such a measure.

Better Management

Actuarial analysis allows management to anticipate rather than react, and thus manage a facility more soundly. Administrators should not view the analysis as solely providing information regarding financial implications, unit turnover forecasts and nursing home utilization. Rather, the analysis can play an integral role in long-range strategic planning. Administrators make decisions such as:

- How many beds need to be available for residents
- The feasibility of using assisted living or home health care instead of nursing care
- When the marketing effort and advertising budget need to be strengthened
- Refurbishment and maintenance efforts on turnover units
- Staffing requirements for the increasing frailty of residents

Actuarial analysis provides administrators with an opportunity rather than a burden. Although risk can never be eliminated from a CCRC, wise use of an actuarial analysis can provide a CCRC with a foundation for future years.

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PLANNING FOR CHANGE IN SENIOR HOUSING

by Morton Yalish, Susan B. Brecht and Howard K. Peters

As the supply of senior housing projects continues to expand, the need to understand the dynamics of each individual marketplace becomes more critical. During the early years of this relatively new industry, seniors had few choices about where to move, and competition was scarce or even non-existent. Now, in many markets, we see numerous projects seeking to fill their units, competing with each other for a relatively finite pool of eligible households.

Competition in today's markets requires sophisticated analyses of the characteristics and attributes of the target market. It is no longer sufficient to look at a homogeneous pool of age and income qualified households to test market depth. Project planners must understand the nature of the markets they target and must consider the effect of changing assumptions on their ability to capture those markets. What if they attract an older segment of the market than they planned? What if project costs result in increased prices before they even open the door? What if housing values decrease or interest rates increase? How might these changes impact project's success? To minimize the risk of failure, market analysis must consider a project within a dynamic—not static—environment, in order to test for and remedy potential weakness, and to weigh the levels of risk associated with the project.

The sensitivity analysis that evaluates various "what if" scenarios has long been the province of financial analysts, particularly since the desktop computer made change so easy to test. As a planning and decision making tool, the sensitivity analysis is equally important when one considers the demographic and economic characteristics of the market for a seniors housing project.

Few markets and few projects remain static from the point of conception to the point at which project marketing and absorption begins. The complexity of the seniors housing business has resulted in market analysis becoming a requisite part of planning. Yet, in many cases, studies that advise organizations about demand and project features do not consider the effect of change. At a minimum, evaluating a project's sensitivity to change within the market context is a risk management strategy.

Conducting a highly effective sensitivity analysis involves developing a set of project assumptions. This analysis is enhanced immeasurably by the availability of a sophisticated set of demographic data. The use of typical aggregate counts of age/income delineated households does not really provide the project team with the ability to evaluate the effects of market segmentation and to assess the strengths and weakness of a given market. Data that provide details on household type, housing tenure, housing and rental values, as well as age and income, enable those planning projects to probe the market in much greater depth. Laventhol & Horwath's ElderCare Site Profile (ESP) provides such information. This data base contains detailed demographic information and thus allows for an in-depth segmentation of the elderly market for a specific area.

The power of sensitivity analysis is best illustrated by example. We have presented in Table 1 the assumption pattern that forms our sample analysis.

These assumptions exemplify many projects which might be in planning stages right now. Our project will open in 1992 and will be offered on a rental basis. Like many other retirement housing communities, we expect that we will draw our residents from the segment aged 75 and above, and that 75 percent of the residents will come from within our defined geographic target market, i.e., the

TABLE ONE

Initial Assumptions

Year Project Opens	1992
Minimum age of resident expected to enter the Project upon its opening	75
Percentage of Household types included:	
One-person households	100%
Husband-wife only households	50%
Other households	30%
Percentage of income allowed for rental expenditure	70%
Rental Fees when the project opens	
One-bedroom	$1,400
Two-bedroom	$1,700
Maximum expected occupancy of the Project	92%
Number of units to be occupied by residents from the target geographic area	75%
Maximum household income for potential resident in 1989 dollars	$75,000
Competitive units in the target geographic area	
One-bedroom	330
Two-bedroom	425
Assumed penetration into eligible households by the project	5%
Assumed earnings on net proceeds from sale of home	8%

area which is reflected in the data we are analyzing. We are proposing a mixture of one- and two-bedroom units that will rent for $1,400 and $1,700 per month (in 1992 dollars). We are assuming that residents will spend approximately 70 percent of their after-tax income on our monthly fee, and that people will move into the most expensive unit they can afford.

Finally, we are assuming that those who own their homes will sell them, netting 90 percent of the sale price after settlement costs, and will be able to invest those proceeds at a yield of 8 percent annually. We are targeting a middle- and upper-middle income market segment, but don't expect to draw from among the really wealthy.

Based on these assumptions, and given the presence of competitive facilities that contain some 755 units, we are able to size the market for our project and determine the number of units that we believe can be absorbed. Table 2 presents the unit potential, assuming that we can achieve a 5 percent penetration of the target market, net of competition.

However, some of these assumptions may change. Knowing that, the project planning team can either keep their fingers crossed, or they can test the effect of change on the project in order

TABLE TWO

Project Unit Potential Based Upon Changes in the Initial Assumptions

SCENARIO	ASSUMPTION CHANGE		CALCULATED PROJECT UNITS TO CONSTRUCT			
	Initial	This Scenario	Bedrooms One	Two	Total	Percent change from initial assumption
Initial Assumptions			64	157	221	N/A
Minimum age of resident to enter the project upon its opening	75	78	33	82	115	−48%
Rental Fees when the project opens One-bedroom Two-bedroom	 $1,400 $1,700	 $1,600 $1,900	42	109	151	−32%
Scenario 2 & 3 combined	(see above)		18	52	70	−68%
Assumed earnings on net proceeds on sale of home	8%	6%	59	120	179	−19%
Assumed earnings on net proceeds on sale of home	8%	10%	78	199	277	25%
Percentage of Households included: Husband-wife only	 50%	 40%	58	139	197	−11%
Maximum household income for potential resident in 1989 dollars	$75,000	$100,000	64	168	232	5%
Maximum household income for potential resident in 1989 dollars	$75,000	$ 50,000	64	131	195	−12%

to determine which variables have the most substantial effect.

Table 2 presents the effect of several changes in the original assumptions presented on the potential unit count. The two variables that have the most dramatic effect on the project are the age of the target market and the rents. The sensitivity of the project to these two variables indicates that the upper age cohorts include relatively few households that are able to afford the original project rents.

Comparing changes in these two variables shows that attracting a much older market than expected will have a more significant effect than would a $200 per month rent increase. The ESP data allow the analyst to consider the effect of home values on project affordability, and also enhances the ability to test market depth at various age levels.

However, should both changes occur, we are left with very little unit potential. Thus, our project planners know from this analysis that they must try to attract households with ages in the mid-70s and control price increases in order to keep the market as deep as possible. Interestingly, the project team can control these variables more than any others. The program and facility design, and highly effective professional marketing should be able to target the 75 year old market segment. Careful planning and experienced management will contribute to their ability to control costs and keep rents in line.

The project planning team can use the results of a sensitivity analysis to further refine project features. If a project must be able to reach a market that includes 75 year olds, not just those 78 and older, what can be done to increase the likelihood of doing so? Unit design and mix may be one area for consideration. The development of larger units, i.e., more square footage, and including cottages as well as apartments might be a strategy for attracting a younger market segment. The service program may also provide opportunities to reach slightly younger people. Providing services on an a la carte basis may draw residents from the younger target market and gives prospective residents greater control over their expenses. This feature might also broaden the project's affordability and serve as a hedge against cost increases.

What is clear from the sensitivity analysis is that changes in basic project assumptions can have a powerful effect upon the depth of the market for any given project. To assume that no change will occur, and to avoid assessing the impact, can result in poor project performance or even failure. Considering the effect of potential change allows the project team to understand the dynamics of its market. Thus, they are able to plan effectively, increasing the project's chances of success.

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All three are located in the firm's Philadelphia office.

ASSISTED LIVING: MATCHING HEALTH NEEDS WITH CARE AND LIVING OPTIONS

by Robert Chelseth and Jerry Serwa

The retirement housing industry's efforts to meet the diverse housing and health care needs of the elderly have prompted the development of increasing varieties of senior living products and services.

One product receiving an enormous amount of attention is assisted living. Defined here as shelter provided in combination with some level of personal care services, assisted living is targeted at those individuals capable of some level of independence, but who need assistance with daily living activities. Typically, this type of care serves as the bridge between independent living and nursing care.

Assisted living has served the frail elderly for decades, bearing names such as board and lodging, sheltered care facilities and homes for the aging. The last several years, however, have witnessed a dramatic increase in assisted living facilities. The aging-in-place dilemma that faces independent facilities, pressure on nursing homes to back out persons to facilities offering less institutionalized and costly forms of care, and a well publicized demographic trend—the increasing number of frail elderly—all contributed to increased demand.

Despite consumer pressure for increased market segmentation and a variety of products and services, the assisted living industry often lacks clear understanding of how to service its clients. At the same time, senior consumers and their families have difficulty distinguishing between assisted living alternatives and the environment they provide. Much of the problem can be traced to the origins of assisted living, which can be best described as an effort to deal with problems in other facilities, rather than as a response to particular market segment. This led assisted living to be deemed, "senior living limbo," where those who did not fit the more easily defined forms of independent living and nursing care were moved.

Defining market niches, or matching products and services with users, requires understanding the nature and extent of the condition imposing limitations on the senior's independence and placing these individuals with the appropriate form of assisted living.

For example, an elderly resident of an independent living facility slips in the parking lot and fractures her hip. At the same facility, a man suffers from the onset of Parkinson's disease. Clearly, both residents need assistance with daily living. But is it in the best interest of the facility and the residents to provide the same living option? Home health care will certainly suit the women who will ultimately regain her health and independence, but what message will healthy seniors receive and what repercussions will the marketing efforts suffer when the degenerative ill and independent seniors reside in one facility?

The accompanying chart provides a overview of the various conditions of the frail elderly and the assisted living options best suited for their needs.

An examination of the chart reveals that many factors influence decisions concerning assisted living. However, the following general conclusions can be made:

- Facilities similar to or connected with independent forms of senior living (including home health care and assisted units in an ACLF) are better suited to seniors whose basis of need is episodic, or so minor as not to pose a major, ongoing need for assistance.
- Freestanding assisted living facilities offer opportunities to serve seniors with chronic conditions, e.g., arthritis, that necessitate assistance with two or three or more basic activities of daily living. If a facility serves those with degenerative illnesses, e.g.,

	HEALTH CONDITION		
	Episodic *Requires assistance in daily living as a result of illness, injury or other temporary health condition. The nature of the condition and the need for services support coincide with the temporary condition. Recovery and return to independent living is expected.*	Chronic *A health condition or disability that is stabilized, but still requires a senior to seek assistance in daily living activities.*	Degenerative Ill *A health problem that results in a steady deterioration of a senior's health and requires increasing levels of personal care and assistance, but has not reached a stage requiring full time skilled care.*
ASSISTED LIVING OPTIONS:			
Home Health Care	Most suitable. Senior is expected to return to good health and independent living. Requires less change (e.g., avoids sale of home). May lack daily support, social contact (especially for seniors living alone) and sense of security. Added burden placed on family and informal care givers.	May be possible, allowing person to stay in home. Issues of cost effectiveness and socialization.	Least desirable option. Difficult to change levels of service in response to changing needs of senior.
Independent Living Facility	Good possibility if the number of units is limited and located separately from independent living units. Allows seniors to stay in independent facility; less trauma.	Wrong environment. Sends wrong signals to healthy independent seniors.	Very poor match. Sends wrong signals to healthy, independent seniors.
CCRCs	Good potential match; portion of independent facility can be used similar to ACLF.	Possible if CCRC is designed with a separate facility for these seniors.	Best suited to CCRC if they have separate facility for assisted living. Can offer added advantage of linkage to nursing component of continuum.
Freestanding Facility	Poor fit as these seniors do not need long term support. Should be working their way out, not looking at maintaining or increasing their support level.	Good fit as the facility can be designed to maximize independence and avoid institutional atmosphere.	Possible fit, as facility can offer a supportive environment without nursing home look. May be best when facility has links to nursing facilities.

Alzheimer's disease, they are better positioned when they have links to nursing care facilities.

- CCRCs offer the opportunity to integrate several forms of care, depending upon the types of facilities that comprise their continuum of care.

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THE RETIREMENT HOUSING INDUSTRY 1989

by James F. Sherman and William R. Evans

For this ninth edition of *Retirement Housing Industry*, the survey methodology and data analysis build upon methodologies used in prior years. Respondents provided more in-depth information about various operating statistics and trends than in previous years.

The data have been organized into the following chapters:
Chapter I: Profile of Participants
Chapter II: General Characteristics
Chapter III: Entrance Fee and Rental Facilities: Operations
Chapter IV: Assisted Living Units/ Facilities

Laventhol & Horwath distributed survey questionnaires to a random sample of retirement housing facilities throughout the United States. The respondent facilities provided operational and financial information for the most recently completed fiscal year. Upon receipt, L&H carefully reviewed completed questionnaires for accuracy and reasonableness.

The sample size, 215 facilities, is the largest since Laventhol & Horwath introduced the study nine years ago. The facilities represent a cross section of the industry in terms of location, size, age and type of facility.

Laventhol & Horwath provides this report because we believe it supplies relevant, timely data about the retirement housing industry. L&H holds all operating and financial data received from respondents in strictest confidence.

All data presented in the exhibits originated from L&H questionnaires and is subject to nonsampling errors, such as differences in the respondents' interpretation of questions. To minimize the effects of these errors, precautionary steps were used during data collection and analysis.

The statistics presented throughout this report are three general types: medians, means and quartiles. Medians were used to prevent any line item from being distorted by an extremely high or low response. A median is the middle figure in a column of data arranged sequentially; half of the responses fall above the median, half below. Medians are based on the information submitted for each individual line item, and not every respondent provided data for each line item. Therefore, columns reported in median amounts will not necessarily equal the totals presented.

In some exhibits, data were presented in quartiles, since these measurements present the range of the data, rather than a single estimate. Quartiles are calculated by dividing the sample into four equal parts.

All figures in this report are intended to serve as guidelines, not as standards or goals. The value of the survey results should be measured by comparisons with previous studies and personal experience. In addition, knowledge of the local market is critical, as local trends may deviate significantly from the data in this report. Laventhol & Horwath is not attempting to set or conform prices or operating ratios for the retirement housing industry.

Any questions about the exhibits or survey methodology should be directed to L&H's Research Division in Philadelphia, (215) 299-1600.

Laventhol & Horwath wishes to acknowledge the valuable contribution of survey participants. This study would not have been possible without them. Each year, respondents and readers have made insightful comments that have helped to refine the survey. We appreciate their participation and welcome your comments.

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CHAPTER I: PROFILE OF PARTICIPANTS

Laventhol & Horwath's ninth annual survey of the retirement housing industry presents data gathered from existing facilities located throughout the United States. This year a record 215 qualified facilities responded, an increase of 22 percent from the previous year.

A retirement facility qualified for inclusion in this report if it met the following definition: non-subsidized, residential housing exclusively for adults who are age 55 and older. In the case of couples, one of the adults must be at least 55 years old. The facility must offer its residents one or more of the following options: meals, activities, laundry/linen service, transportation and access to nursing services.

This broad definition is used because of the wide range of housing and service options that exist in this industry. The respondent facilities offer a variety of options and include entrance fee facilities (both refundable and non-refundable), rental facilities, condominiums and cooperatives. Communities that include basic services in the monthly fee are included, as well as communities that charge "a la carte" for these services.

EXHIBIT I: Regional Distribution of Participants

The respondent facilities are located in 41 states and the District of Columbia. California and Florida have the most respondents, 34 and 24 respectively. The projected 1990 Census Bureau distribution of the elderly has been included for comparison.

Composition of the Regions:

NORTHEAST—CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT

SOUTHEAST—AL, DC, FL, GA, KY, MD, NC, SC, TN, VA, WV

NORTH CENTRAL—IL, IN, IA, MI, MN, NE, ND, OH, SD, WI,

SOUTH CENTRAL—AR, KS, LA, MO, MS, OK, TX

WEST—AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA, WY

Region	Number of Respondents	Percent of Respondents	1990 Estimate Percent of Total Population Over Age 65(1)
U.S.	215	100.0%	100.0%
NORTHEAST	30	13.9	22.7
SOUTHEAST	47	21.9	23.8
NORTH CENTRAL	46	21.4	21.1
SOUTH CENTRAL	24	11.2	14.0
WEST	68	31.6	18.4

(1) U.S. Bureau of Census—Current Population Reports—series P-25, No. 1017.

EXHIBIT II: Distribution of Facilities by Type

Respondent facilities have been classified based upon the payment options available to their residents and other major characteristics. Throughout the report, the following distinctions are made:

Entrance Fee Facilities (Type I):

Facilities that charge an entrance (endowment) fee are further divided based upon the facility's orientation.

Principally Retirement Centers (Type IA) represent facilities with a ratio of more than two independent living units (apartments) to each nursing bed. This category includes facilities known as continuing care retirement communities, which typically contain a large number of apartments and a smaller nursing center.

Nursing Care Oriented Facilities (Type IB) are those entrance fee facilities with fewer than two independent living apartments per nursing bed.

Rental Facilities (Type II):
Rental facilities charge only a monthly service fee. While some rental facilities reported an "entrance fee," when this figure was equal or double the monthly fee, it was considered to be a security deposit for the purpose of this study.

Assisted Living Facilities (Type III):
Reflecting a growing trend in the industry, this year's study includes statistics about facilities composed solely of assisted living units, with or without a nursing center. Although definitions of assisted living vary greatly between the states, for the purpose of this study, assisted living has been defined as a transitional level of care between independent living and the lowest level of nursing care. The lowest level of nursing care is often called personal care or sheltered care.

EXHIBIT III: Comparison of Total Apartment Units and Nursing Beds

The distinction between the two types of entrance fee communities is apparent in this exhibit. Type IA principally retirement communities contain significantly more independent living units per nursing bed than Type IB nursing care oriented facilities. When the Type IA communities without on-site nursing beds are eliminated, the ratio becomes approximately 4:1, which many state regulations mandate. Ninety percent of assisted living facilities responding to the survey were dedicated to assisted living and contained neither independent living units nor nursing beds.

	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities	Assisted Living Facilities
TOTAL APARTMENT UNITS	11,464	3,413	12,579	2,951
TOTAL NURSING BEDS	1,911	3,695	1,511	75
RATIO: APARTMENTS / NURSING BEDS (All facilities)	6.0:1	0.9:1	8.3:1	39:1
RATIO: APARTMENTS / NURSING BEDS (Includes only facilities with nursing beds)	3.8:1	0.9:1	1.4:1	1.7:1

EXHIBIT IV: Regional Distribution of Participants by Type of Facility

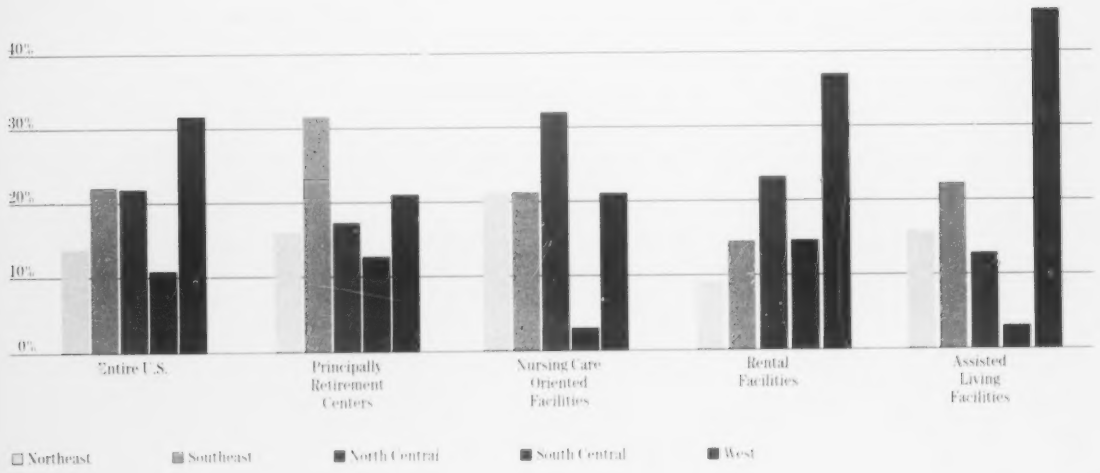
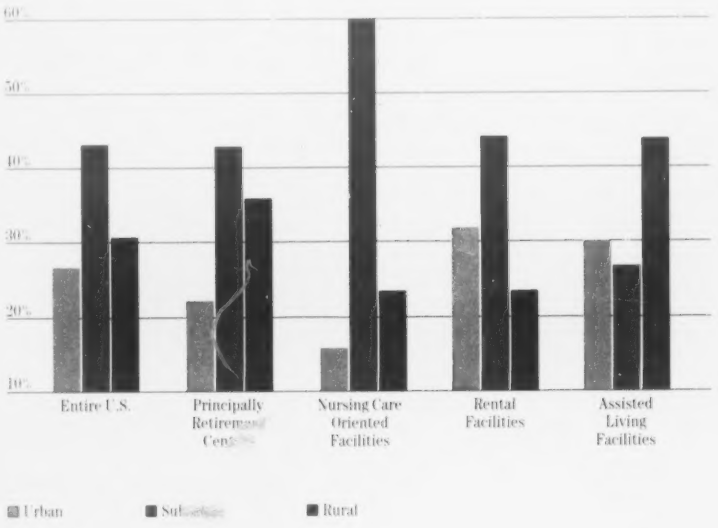


Exhibit IV provides further analysis of the regional distribution of respondents. Facilities located in the Southeast and North Central were more likely to be entrance fee communities, while in the West rental facilities were the most common. Most of the assisted living facilities responding to the survey are located in the West. Exhibit I provides an explanation of the regions.

EXHIBIT V: Facility Location by Type of Facility

For the purpose of this study, an urban area is defined as a town or city with a population greater than 500,000; a rural area is defined as a town with less than 50,000 inhabitants. A suburban location includes cities or towns with 50,000 to 500,000 residents.

In this year's sample, all facility types are more commonly found in suburban areas. While rural areas may have the land to build retirement facilities, particularly the larger campus settings of a principally retirement center, a rural population may not be able so support these facilities. Median facility sizes are included for comparison. As in past years, Type IA facilities tend to have the greatest number of independent living units and are the largest facilities in overall size.



Entire U.S. Median Number of Independent Living Units
Principally Retirement Centers: 170 Units
Nursing Care Oriented Facilities: 144 Units
Rental Facilities: 101 Units
Assisted Living Facilities: Not Applicable

One look at the white rambling house with a pitched roof, lattice trim and an inviting front porch, and you may think it's a farmhouse in a Midwestern homestead. Rather, it's a suburban Minneapolis home for not one family, but for 28 individuals who need assistance with living.

It's little wonder that Elder Homestead made waves in the retirement housing community. Designed by Arvid Elness Architects, this assisted living facility bridges the gap between nursing care and independent living facilities. Its design offers residents not

Elder Homestead
Minnetonka, Minnesota

only a feeling of home but also caring and independence.

The exterior is pure Americana, but the interior is city sophistication, with plush carpets, a grand staircase and Doric columns.

"Institutional does not make it any more helpful," said Robert Peterson, President of Elder Homestead Corporation. But make no mistake, the residents are frail and assistance with living is incorporated into the design, with seats adjacent to elevators, wide doorways, guardrails and bathrooms designed for safety.

The core of the design is the cluster structure. All residents have their own rooms with kitchens (fostering independence) and every four rooms surrounds a lounge. Seven clusters fill the house.

"The cluster is like a neighborhood," said Peterson. Residents form a bond and yet have the privacy of their rooms. Each room has a window and a half-door that overlook the lounge, allowing residents to chose the amount of interaction they desire.

Noting the success of the clusters, Peterson said relationships form according to dictates of residents, with some clusters forming strong ties. Residents discord has been minimal, which Peterson attributed to all residents having their own space, common areas other than the lounges, and self-selection of this living arrangement.

Despite the success that the nearly 100 percent occupancy demonstrates, would Peterson change anything? Yes, he would make the facility larger, for financial and social reasons—as he says, finding four bridge players in a group of 28 is tough.

CHAPTER II: GENERAL CHARACTERISTICS

*EXHIBIT II-1: Independent Living Unit Mix by Type and Age of Facility**

The major trends in the size of independent living units are similar to last year's analysis. Survey results reveal larger units are in greater demand; newer facilities tend to be smaller than those built during the past decade; and, except in rental facilities, studios without kitchens are no longer a popular option. Also, nursing care oriented facilities (those with two or more times the number of nursing beds compared to independent living units) are not being developed in great numbers.

This year's data still indicate that waiting lists for larger units tend to be longer than for smaller units (Exhibit II-7), despite developers' attempts to include a greater number of larger units. New to this year's study is an analysis of the mix of one- and two-bedroom cottages/duplexes.

TYPE OF UNIT	BUILT BEFORE 1975			BUILT 1975-1984			BUILT 1985 & LATER		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
ENTIRE U.S.:									
Studio w/out Kitchen	22 units	51 units	95 units	12 units	25 units	55 units	6 units	38 units	56 units
Studio	12	40	75	9	22	36	9	17	32
One-Bedroom	19	39	60	15	49	79	20	51	97
One-Bedroom Deluxe	6	18	28	9	22	47	15	24	40
Two-Bedroom	5	15	33	10	27	51	14	23	46
Two-Bedroom Deluxe	3	9	16	4	13	33	4	13	43
Three-Bedroom	2	3	11	1	4	10	2	10	24
Cottage-Duplex (One-Bedroom)	7	12	20	3	12	28	4	12	17
Cottage-Duplex (Two-Bedroom)	6	27	36	9	25	72	7	20	22
Total Units	60	111	196	95	128	209	71	115	179
PRINCIPALLY RETIREMENT CENTERS:									
Studio w/out Kitchen	13	52	88	5	29	122	**	**	**
Studio	18	40	73	11	26	41	9	16	27
One-Bedroom	23	44	57	43	73	91	23	46	93
One-Bedroom Deluxe	7	16	21	7	19	36	15	22	49
Two-Bedroom	3	17	29	12	36	58	20	38	51
Two-Bedroom Deluxe	1	9	12	5	11	39	4	14	48
Three-Bedroom	2	8	12	**	7	**	**	15	**
Cottage-Duplex (One-Bedroom)	2	7	58	**	15	**	**	10	**
Cottage-Duplex (Two-Bedroom)	1	32		3	13	73	12	20	50
Total Units	100	161	267	99	177	267	80	167	226
NURSING CARE ORIENTED FACILITIES:									
Studio w/out Kitchen	**	**	**	**	**	**	**	**	**
Studio	4	12	29	9	11	24	12	82	152
One-Bedroom	27	49	59	16	24	74	**	40	**
One-Bedroom Deluxe	10	20	62	6	21	115	**	46	**
Two-Bedroom	9	17	36	16	24	59	**	**	**
Two-Bedroom Deluxe	6	17	20	5	23	103	**	**	**
Three-Bedroom	**	**	**	2	4	4	**	**	**
Cottage-Duplex (One-Bedroom)	8	13	22	4	12	28	**	**	**
Cottage-Duplex (Two-Bedroom)	26	33	49	9	21	94	**	**	**
Total Units	66	137	210	100	165	241	12	52	149
RENTAL FACILITIES:									
Studio w/out Kitchen	22	30	99	3	19	50	5	41	73
Studio	12	57	82	7	23	47	8	19	42
One-Bedroom	13	33	83	10	44	78	20	71	96
One-Bedroom Deluxe	5	29	31	9	31	66	11	21	36
Two-Bedroom	5	11	21	3	13	35	8	14	35
Two-Bedroom Deluxe	2	9	29	4	4	19	3	9	35
Three-Bedroom	1	2	3	1	3	25	**	**	**
Cottage-Duplex (One-Bedroom)	**	**	**	**	**	**	**	**	**
Cottage-Duplex (Two-Bedroom)	**	**	**	**	**	**	**	**	**
Total Units	44	84	161	56	120	142	71	108	151

*Each item was individually tabulated and does not necessarily add to the totals shown.
**Insufficient response.

EXHIBIT II-2: Resident Origin by Region

Research continues to prove that, "All retirement housing is local." Retirement community residents tend to originate from the towns immediately surrounding the facility. However, a major exception is the Southeast region—including Florida. This region is the most likely to attract out-of-state residents.

MEDIAN PERCENTAGE OF RESIDENTS MOVING TO A NEW STATE TO ENTER THE RETIREMENT COMMUNITY

Entire U.S.	10.0%
Northeast	10.4
Southeast	18.0
North Central	9.0
South Central	5.0
West	10.0

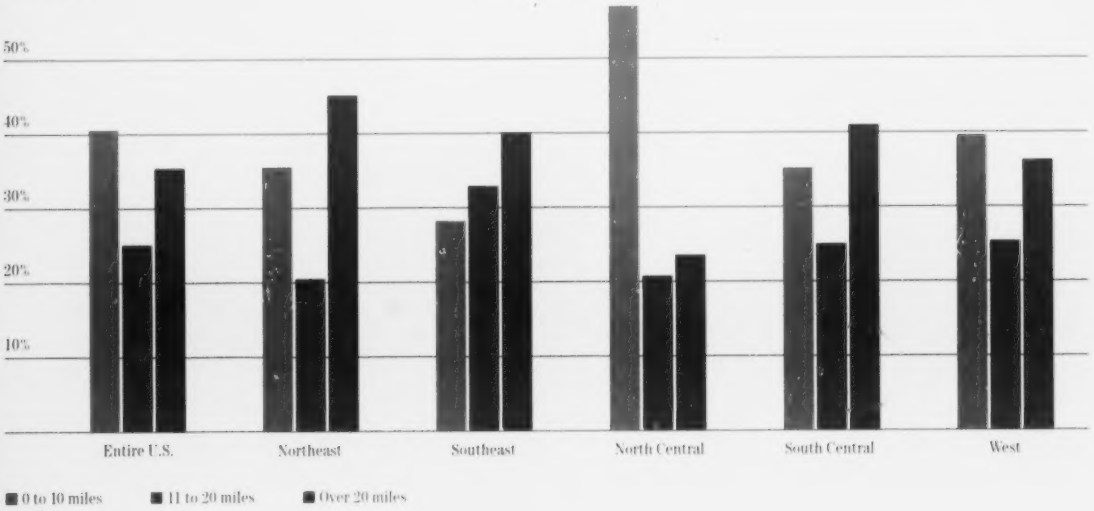


EXHIBIT II-3: Resident Origin by Type of Facility

Exhibit II-3 substantiates the trend reported in Exhibit II-2. Only minor differences exist between facility types when resident origin is examined. Consistent with the results of past studies, Type IA principally retirement centers are more likely to draw residents from over 25 miles. Regardless of facility type, the respondent facilities drew more than 50 percent of their residents from within 15 miles.

These observations have important impact upon the market analysis of a potential community. Of course, individual facilities may deviate from these results. Some facilities draw residents from much smaller distances. Understanding the migration patterns and the market appeal of a retirement housing project is critical for success.

DISTANCE	Under 5 miles	5-10 Miles	11-15 Miles	16-20 Miles	21-25 Miles	Over 25 Miles
PRINCIPALLY RETIREMENT CENTERS	16.3%	18.3%	15.7%	9.6%	14.0%	26.1%
NURSING CARE ORIENTED FACILITIES	18.0	28.0	10.2	10.2	13.5	20.1
RENTAL FACILITIES	22.6	18.9	11.4	12.3	11.5	23.3

*EXHIBIT II-4: Involvement of Particular Individuals in Selection of Community by Type of Facility**

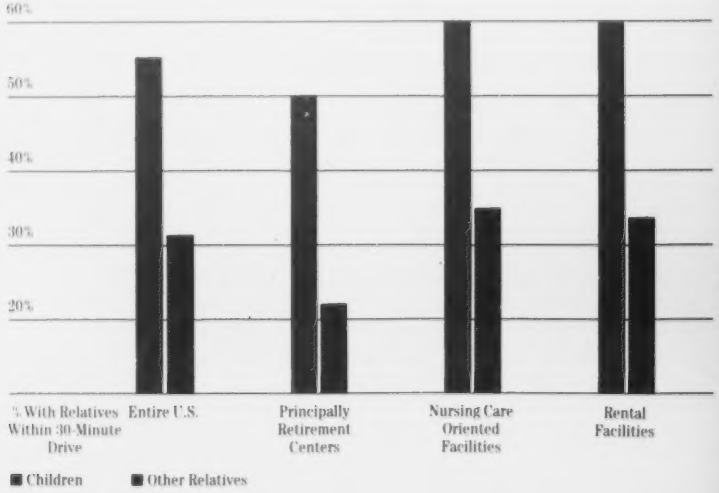
Children continue to play an important role in selecting retirement communities, according to the respondent facilities. However, many individuals partake in the decision-making process. Current residents and physicians/ medical personnel play an important role in recommending the facility, suggesting additional marketing strategies should target these important referral sources. The effectiveness of various marketing strategies is reported in Exhibit II-9.

INDIVIDUALS	No Involvement	Recommended Facility to Resident	Visited Facility with Resident	Participated in Closing/Leasing
PRINCIPALLY RETIREMENT CENTERS:				
Children	10.0%	2.0%	46.0%	42.0%
Clergy	40.0	54.0	4.0	2.0
Current Residents	4.0	60.0	28.0	8.0
Financial Advisor	8.0	48.0	36.0	8.0
Friends	42.0	36.0	8.0	14.0
Lawyer	18.0	40.0	28.0	14.0
Other Relatives	38.0	46.0	2.0	14.0
Physician/Medical Personnel	28.0	68.0	0.0	4.0
NURSING CARE ORIENTED FACILITIES:				
Children	0.0%	4.2%	45.8%	50.0%
Clergy	20.8	75.0	0.0	4.2
Current Residents	4.2	58.3	33.3	4.2
Financial Advisor	16.7	37.5	41.7	4.1
Friends	50.0	37.5	4.2	8.3
Lawyer	16.7	45.8	29.2	8.3
Other Relatives	54.2	37.5	4.2	4.1
Physician/Medical Personnel	25.0	66.7	4.2	4.1
RENTAL FACILITIES:				
Children	4.5%	3.0%	35.8%	56.7%
Clergy	40.3	58.2	0.0	1.5
Current Residents	4.5	71.6	17.1	6.0
Financial Advisor	10.5	49.3	31.3	8.9
Friends	58.2	28.4	7.5	5.9
Lawyer	19.4	32.8	31.3	16.5
Other Relatives	59.7	34.3	4.5	1.5
Physician/Medical Personnel	19.4	23.1	4.5	3.0

*All amounts are medians.

*EXHIBIT II-5: Resident Proximity to Children and Other Relatives by Type of Facility**

The majority of residents have children living within a thirty-minute drive of their retirement facility, according to the survey results. Residents of Type I principally retirement centers are somewhat less likely to have children living nearby; this may be due in part to the increased tendency of these residents to come from out-of-state.



*All amounts are medians.

EXHIBIT II-6: Number of Persons on Waiting List by Type of Facility

Fifty-eight percent of respondent facilities reported a waiting list. The median waiting size was 35 individuals, while the longest waiting list contained 800 persons. Approximately ten percent of facilities indicated plans to expand the number of independent living units. Type III assisted living units had the shortest waiting list. This may be explained by the need-driven decision to move into an assisted living arrangement, which often does not allow the individual the option of waiting until space becomes available.

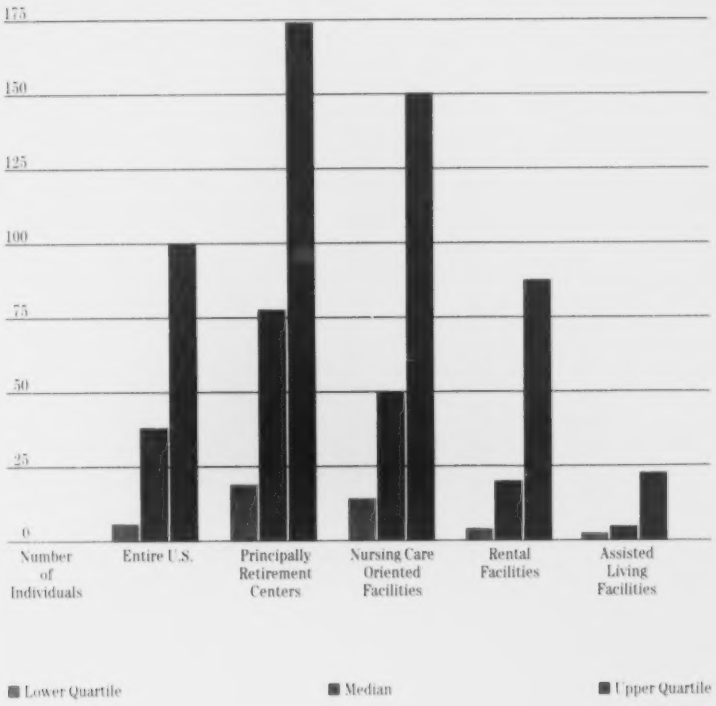


*EXHIBIT II-7: Length of Waiting List by Unit Type by Type and Age of Facility**

Consistent with the results of previous studies, larger units tend to have longer waiting lists, especially among older facilities that have fewer larger units (Exhibit II-1). Facilities built after 1985 were the least likely to report waiting lists, which may reflect that many of these facilities are in their initial fill-up period and have not yet obtained stable occupancy. Only the fifty-eight percent of respondent facilities that had waiting lists are included in these statistics.

TYPE OF UNIT	PRINCIPALLY RETIREMENT CENTERS			NURSING CARE ORIENTED FACILITIES			RENTAL FACILITIES		
	Built Before 1975	Built 1975-1984	Built 1985 & Later	Built Before 1975	Built 1975-1984	Built 1985 & Later	Built Before 1975	Built 1975-1984	Built 1985 & Later
Studio w/out Kitchen	0 months	**	**	**	**	**	3.1 months	3.0 months	2.0 months
Studio	2.0	6.0 months	13.0 months	4.0 months	7.5 months	**	3.5	3.0	6.0
One-Bedroom	19.5	6.0	6.0	7.5	9.8	**	12.0	6.0	3.0
One-Bedroom Deluxe	12.0	10.0	6.0	3.0	15.0	**	6.0	2.0	**
Two-Bedroom	19.5	18.0	15.0	8.0	6.0	**	18.0	7.0	3.0
Two-Bedroom Deluxe	12.0	24.0	**	2.0	12.5	**	12.9	9.0	**
Three Bedroom	18.0	**	**	**	**	**	**	**	**
Cottage/Duplex (all types)	12.0	**	**	21.0	**	**	24.0	**	**

*All amounts are medians.
**Insufficient response.

EXHIBIT II-8: Marketing Techniques by Location and Type of Facility

A wide range of marketing techniques are used to attract potential retirement housing residents. Exhibit II-8 reports the popularity of selected marketing methods. Newspaper advertising, press releases and direct mail brochures are the most popular marketing techniques for all facilities. When compared with previous years, an increasing number of retirement facilities reported using both radio and television campaigns.

MARKETING TECHNIQUE	URBAN		SUBURBAN		RURAL	
	Never Used	Used in Past / Currently Using	Never Used	Used in Past / Currently Using	Never Used	Used in Past / Currently Using
PRINCIPALLY RETIREMENT COMMUNITIES:						
Newspaper Advertising	15.4%	84.6%	15.0%	85.0%	11.8%	88.2%
Magazine Advertising	38.5	61.5	56.5	43.5	47.1	52.9
Television	61.5	38.5	54.6	45.4	52.6	47.4
Radio	46.2	53.8	45.6	54.4	50.0	50.0
Press Releases	7.7	92.3	10.0	90.0	6.7	93.3
Direct Mail Brochures	7.7	92.3	18.2	81.8	12.5	87.5
Community Outreach/Religious	23.1	76.9	22.7	77.3	18.8	82.2
Community Outreach/Sr. Citizens	25.0	75.0	31.8	68.2	12.5	87.5
Activities for Residents' Children	50.0	50.0	52.2	47.8	76.9	23.1
NURSING CARE ORIENTED FACILITIES:						
Newspaper Advertising	25.0%	75.0%	16.7%	83.3%	20.0%	80.0%
Magazine Advertising	75.0	25.0	54.6	45.4	75.0	25.0
Television	75.0	25.0	69.2	30.8	50.0	50.0
Radio	50.0	50.0	46.2	53.8	75.0	25.0
Press Releases	25.0	75.0	9.1	90.1	20.0	80.0
Direct Mail Brochures	25.0	75.0	16.7	83.3	25.0	75.0
Community Outreach/Religious	25.0	75.0	18.2	81.8	60.0	40.0
Community Outreach/Sr. Citizens	50.0	50.0	27.3	72.3	60.0	40.0
Activities for Residents' Children	75.0	25.0	36.4	63.6	25.0	75.0
RENTAL FACILITIES:						
Newspaper Advertising	4.6%	95.4%	15.2%	84.8%	27.8%	72.2%
Magazine Advertising	56.5	43.5	48.3	51.7	63.2	36.8
Television	68.2	31.8	46.4	53.6	83.3	16.7
Radio	26.1	73.9	38.5	61.5	35.3	64.7
Press Releases	14.3	85.7	23.3	76.7	21.1	78.9
Direct Mail Brochures	4.6	95.4	18.8	81.2	21.1	78.9
Community Outreach/Religious	9.5	90.5	15.6	84.4	25.0	75.0
Community Outreach/Sr. Citizens	9.5	90.5	25.8	74.2	30.0	70.0
Activities for Residents' Children	41.0	60.0	40.7	59.3	52.9	47.1

EXHIBIT II-9: Effectiveness of Marketing Techniques

Direct mail continues to be judged as one of the most effective marketing techniques used by the respondent facilities, as does community outreach to religious and community groups. Despite the increased use of electronic media (Exhibit II-8), facilities differed in their reviews of its effectiveness. Variations in the effectiveness are noted among urban, suburban and rural facilities and between facility types. This is further evidence of the complexity of marketing in the industry.

MARKETING TECHNIQUE	URBAN			SUBURBAN			RURAL		
	Not Effective	Somewhat Effective	Very Effective	Not Effective	Somewhat Effective	Very Effective	Not Effective	Somewhat Effective	Very Effective
PRINCIPALLY RETIREMENT CENTERS:									
Newspaper Advertising	0.0%	80.0%	20.0%	0.0%	50.0%	50.0%	11.8%	52.9%	35.3%
Magazine Advertising	22.2	55.6	22.2	10.0	90.0	0.0	27.3	54.6	18.1
Television	25.0	75.0	0.0	40.0	50.0	10.0	25.0	75.0	0.0
Radio	28.6	57.1	14.3	45.5	27.3	27.2	22.2	55.6	22.2
Press Releases	0.0	75.0	25.0	10.5	73.7	15.8	0.0	66.7	33.3
Direct Mail Brochures	0.0	45.5	54.5	5.9	47.0	47.1	0.0	29.4	70.6
Community Outreach/Religious	9.1	72.7	18.2	12.5	56.3	31.3	6.7	73.3	20.0
Community Outreach/Sr. Citizens	11.1	66.7	22.2	21.4	42.9	35.7	18.8	68.8	12.4
Activities for Residents' Children	0.0	80.0	20.0	25.0	50.0	25.0	16.7	83.3	0.0
NURSING CARE ORIENTED FACILITIES:									
Newspaper Advertising	0.0%	66.7%	33.3%	30.0%	40.0%	30.0%	0.0%	100.0%	0.0%
Magazine Advertising	0.0	100.0	0.0	50.0	50.0	0.0	0.0	100.0	0.0
Television	**	**	**	**	**	**	**	**	**
Radio	50.0	50.0	0.0	33.3	50.0	16.7	0.0	66.7	33.3
Press Releases	**	**	**	9.1	72.7	18.2	20.0	80.0	0.0
Direct Mail Brochures	75.0	75.0	0.0	0.0	54.5	45.5	0.0	80.0	20.0
Community Outreach/Religious	66.7	33.3	0.0	9.1	81.8	9.1	0.0	100.0	0.0
Community Outreach/Sr. Citizens	0.0	0.0	100.0	0.0	80.0	20.0	0.0	100.0	0.0
Activities for Residents' Children	**	**	**	10.0	60.0	30.0	0.0	75.0	25.0
RENTAL FACILITIES:									
Newspaper Advertising	13.6%	45.5%	40.9%	7.1%	67.9%	25.0%	14.3%	71.4%	14.3%
Magazine Advertising	20.0	70.0	10.0	37.5	56.3	6.2	33.3	67.7	0.0
Television	33.3	50.0	16.7	6.7	66.7	26.6	33.3	67.7	0.0
Radio	33.3	61.1	5.6	37.5	56.3	6.2	10.0	80.0	10.0
Press Releases	13.3	60.0	26.7	14.3	71.4	14.3	6.7	66.7	26.6
Direct Mail Brochures	10.0	55.0	35.0	11.1	55.6	33.3	6.3	68.8	24.9
Community Outreach/Religious	10.0	70.0	30.0	3.6	53.6	42.8	6.7	80.0	13.3
Community Outreach/Sr. Citizens	15.0	70.0	15.0	8.3	58.3	33.4	7.1	71.4	21.5
Activities for Residents' Children	0.0	57.1	42.9	17.7	47.1	35.2	17.5	75.0	25.0

**Insufficient response.

*EXHIBIT II-10: Preconstruction Sales Results and Fill-up Period by Type of Facility**

Various lending requirements and state regulations mandating sales volume prior to construction contribute to lengthy preconstruction periods among respondent facilities.

Caution is urged in interpreting the occupancy results reported in Exhibit II-10. When added to the construction sales/lease period, the time to reach stable occupancy approaches a median length of three years for Type I principally retirement communities. Half of the facilities reported significantly more time was necessary to achieve stable occupancy. The fill-up time has important financial implications for retirement housing facilities and must be adequately understood and funded. Again, understanding the market is critical.

	PERCENT WITH PRECONSTRUCTION SALE/LEASE PERIOD	LENGTH IN MONTHS
Entire U.S.	46.1	12
Principally Retirement Centers	64.7	16
Nursing Care Oriented Facilities	54.2	12
Rental Facilities	38.2	6

	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
SALES/LEASES ACHIEVED DURING PRECONSTRUCTION PERIOD	50.0%	55.0%	26.5%
CUMULATIVE PERCENTAGE OF UNITS FILLED DURING:			
0-6 Months of Occupancy	50.7%	64.8%	72.8%
7-12 Months of Occupancy	60.3	98.9	83.3
13-18 Months of Occupancy	78.6	99.4	100.0
19-24 Months of Occupancy	95.8	100.0	100.0
25-30 Months of Occupancy	98.5	100.0	100.0
31-36 Months of Occupancy	98.4	100.0	100.0
NUMBER OF MONTHS REQUIRED TO REACH 95% OCCUPANCY	17.5 months	10.5 months	11.0 months

*All amounts are medians.

*EXHIBIT II-11: Marketing Costs per Unit by Facility Type**

The wide variations in marketing costs reported last year are once again apparent. Type I principally retirement communities tend to incur greater marketing expenses. Factors contributing to this include the necessity of providing more education about Type I facilities—which usually offer continuing care contracts—and the tendency of potential residents to take time making decisions and make repeat visits to the facilities. Type II rental facilities are an easier concept to explain and market to prospects, thus lower marketing expenses.

	PRINCIPALLY RETIREMENT CENTERS			NURSING CARE ORIENTED FACILITIES			RENTAL FACILITIES		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Cost/Unit First Phase	$1,976	$5,200	$7,091	**	$3,500	**	$497	$1,382	$3,487
Cost/Unit Subsequent Phases	**	552	**	**	675	**	265	652	1,148
Cost/Unit Remarketing	452	1,425	2,779	**	779	**	120	400	525

*Cost/Unit Remarketing is for all facilities. Other costs are for facilities built after 1980.
**Insufficient response.

*EXHIBIT II-12: Annual Marketing Expenses**

Annual marketing expenses follow the trends reported in previous studies. Older facilities tend to have lower marketing expenses than newer facilities, with facilities built since 1985 incurring the largest marketing expense. Since many newer facilities have not achieved stable occupancy (Exhibit II-19), it is not surprising that they incur higher marketing costs.

	BUILT BEFORE 1975			BUILT 1975-1984			BUILT 1985 & LATER		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:									
Salaries	$15,250	$35,000	$ 70,500	$ 4,000	$31,500	$ 56,908	$26,830	$ 40,600	$ 85,675
Commissions	0	0	0	0	0	2,075	0	200	19,400
Marketing Company	0	0	0	0	0	0	0	0	0
All Other	0	0	51,027	695	6,578	52,744	0	54,440	120,000
Total Budget	$15,250	$37,500	$196,250	$ 5,250	$45,200	$104,989	$95,622	$172,285	$250,000
NURSING CARE ORIENTED FACILITIES:									
Salaries	**	$29,406	**	$10,050	$21,000	$ 42,500	**	**	**
Commissions	**	0	**	0	0	3,650	**	**	**
Marketing Company	**	0	**	0	0	0	**	**	**
All Other	**	16,250	**	11,250	30,000	50,250	**	**	**
Total Budget	**	$60,503	**	$36,600	$50,000	$ 3,000	**	**	**
RENTAL FACILITIES:									
Salaries	0	$15,000	$ 25,000	$ 2,300	$17,100	$ 27,000	$ 3,750	$ 38,000	$120,000
Commissions	0	0	0	0	1,000	9,750	0	0	13,000
Marketing Company	0	0	0	0	0	0	0	0	13,875
All Other	2,500	5,000	20,000	0	5,212	39,493	1,850	13,000	99,613
Total Budget	$ 8,060	$20,000	$ 31,750	$22,000	$28,800	$ 60,033	$36,250	$142,500	$349,000

*Each item individually tabulated and does not necessarily add to totals shown.
**Insufficient response.

*EXHIBIT II-13: Financial Screening and Financial Assistance Provided to Residents by Type of Facility**

Potential residents of retirement facilities are likely to be screened for both financial resources and medical conditions prior to acceptance by a facility. The minimum financial standards for a couple changed insignificantly from last year's survey, with Type I entrance fee facilities requiring a larger financial base for residents. This is not surprising, given the often significant entrance fees charged by these facilities (Exhibit III-13).

FACILITIES SCREENING RESIDENTS FOR MEDICAL CONDITIONS

Entire U.S.	96.7%
Principally Retirement Centers	97.4
Nursing Care Oriented Facilities	92.8
Rental Facilities	96.9

	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
SCREEN RESIDENTS FOR FINANCIAL CAPABILITIES	87.1%	80.8%	49.5%
MINIMUM STANDARDS FOR COUPLE:*			
Assets (Including home)	$100,000	$130,000	$75,000
Gross Annual Income	20,000	20,000	15,250
PROVIDE ASSISTANCE TO RESIDENTS OF:			
Independent Living Units	45.8%	68.0%	28.3%
Nursing Center:			
Provide Assistance	41.8%	91.4%	13.5%
Do Not Provide Assistance	25.4	4.3	24.3
Covered Through Initial Fee	16.4	4.3	2.7
Do Not Have Nursing Center	16.4	0.0	59.5

*Minimum standards are medians.

EXHIBIT II-14: Residents Requiring Financial Assistance and Annual Costs

Financial screening usually appears to limit the number of residents that require financial assistance from respondent facilities. Current and estimated financial assistance represent that portion of fees that residents are or will be incapable of paying. These amounts are consistent with prior year's results.

TYPE OF FACILITY	RESIDENTS CURRENTLY REQUIRING FINANCIAL ASSISTANCE			RESIDENTS WHO WILL EVENTUALLY REQUIRE FINANCIAL ASSISTANCE			Current Annual Expense of Financial Assistance*	Estimated 1994 Expense of Financial Assistance*
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile		
PRINCIPALLY RETIREMENT CENTERS	0.0%	1.7%	10.5%	1.0%	3.8%	10.0%	$27,000	$ 40,000
NURSING CARE ORIENTED FACILITIES	1.0	7.0	20.0	5.0	9.5	29.5	61,980	100,000
RENTAL FACILITIES	0.0	5.0	23.0	0.0	10.0	30.0	20,000	27,500

*All amounts are medians.

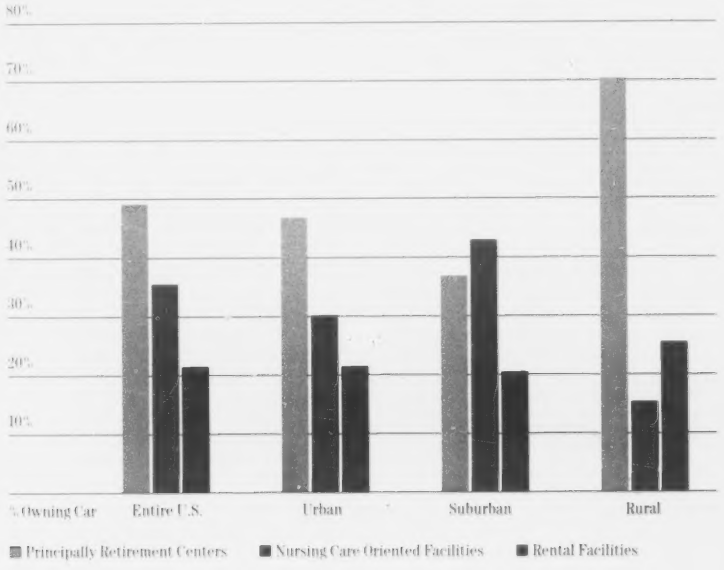
EXHIBIT II-15: Reserve Funds

Reserve funds are those monies that are reserved for purposes other than for debt service or mortgage repayment. Reserves may reflect requirements of lenders, as well as the reserves to provide guaranteed health care to residents. Type II rental facilities are unlikely to provide guaranteed health care and consequently have much lower reserve levels. As facilities with guaranteed health care contracts perform actuarial studies of future health care liabilities, reserves may increase.

	ENTIRE U.S.		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
Total Amount of All Reserves	$ 282,842	$ 605,000	$2,591,380
Total Reserves per Resident	1,613	5,174	22,168
NURSING CARE ORIENTED FACILITIES:			
Total Amount of All Reserves	$886,000	$3,329,347	$4,898,170
Total Reserves per Resident	16,249	21,429	73,529
RENTAL FACILITIES:			
Total Amount of All Reserves	$62,943	$152,633	$429,250
Total Reserves per Resident	677	2,182	6,023

*EXHIBIT II-16: Car Ownership by Residents by Type and Location of Facility**

Consistent with previous studies, residents of Type II rental facilities tend to be the least likely to own automobiles, and these facilities are the least likely to offer transportation services. Public concern over safety issues and elderly drivers is mounting, particularly in states with large populations of seniors. Facilities of all types should carefully monitor developments in this area.



*All amounts are medians.

*EXHIBIT II-17: Parking Spaces by Type and Location of Facility**

For many facilities in the development stage, providing adequate parking becomes critical in obtaining zoning approval. Urban facilities of all types tend to provide the fewest number of parking spaces, which is not surprising since residents, employees and guests of many urban facilities have access to public transportation.

LOCATION	Residents	Employees	Guests	Other	Total
PRINCIPALLY RETIREMENT CENTERS:					
Urban	86	30	30	3	116
Suburban	95	62	24	14	214
Rural	99	42	13	0	150
NURSING CARE ORIENTED FACILITIES:					
Urban	**	**	**	**	**
Suburban	69	60	30	12	214
Rural	**	**	**	**	92
RENTAL FACILITIES:					
Urban	47	22	**	**	53
Suburban	20	14	16	**	63
Rural	25	30	15	**	68

*All amounts are medians. Each item was individually tabulated and does not necessarily add to totals shown.
**Insufficient response.

EXHIBIT II-18: Scheduled Transportation by Type of Facility

The majority of retirement housing communities provide transportation services to their residents, both on a scheduled and as needed basis. Charging additional fees for non-scheduled trips is a common practice as well. Transportation service is considered a critical component of a retirement housing facility's service package. This becomes even more important as residents age and become more frail and dependent.

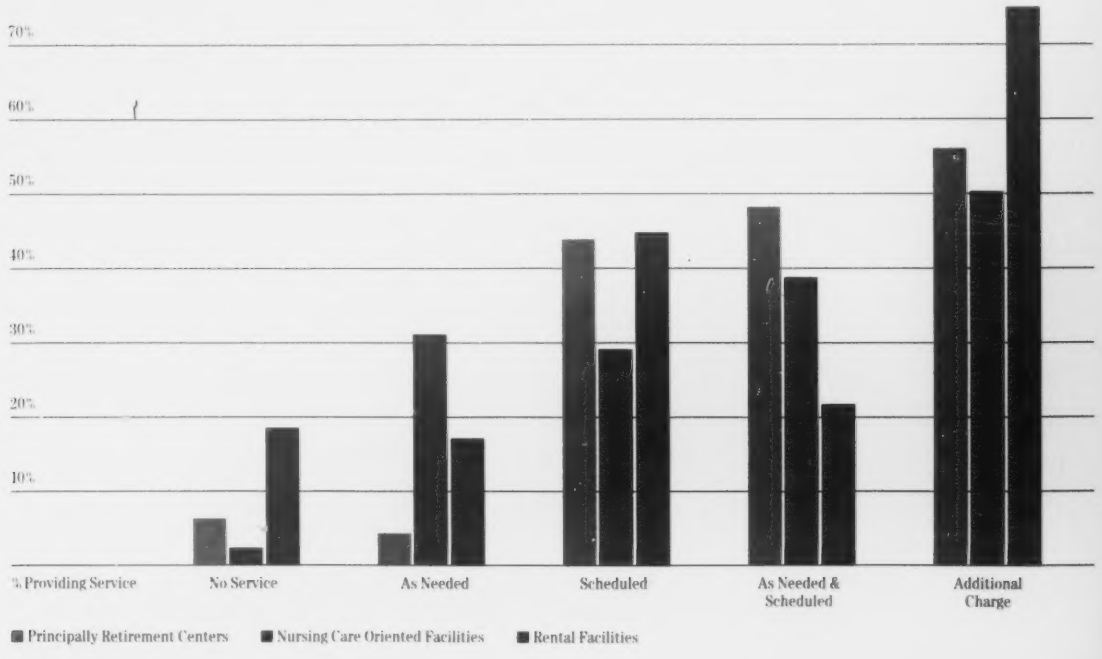


*EXHIBIT II-19: Occupancy Rates by Selected Criteria**

With the exception of Type IA principally retirement centers built after 1985, occupancy rates among the respondent facilities remained high. Many of the newer Type IA facilities are still in their initial fill-up period, which can last several years.

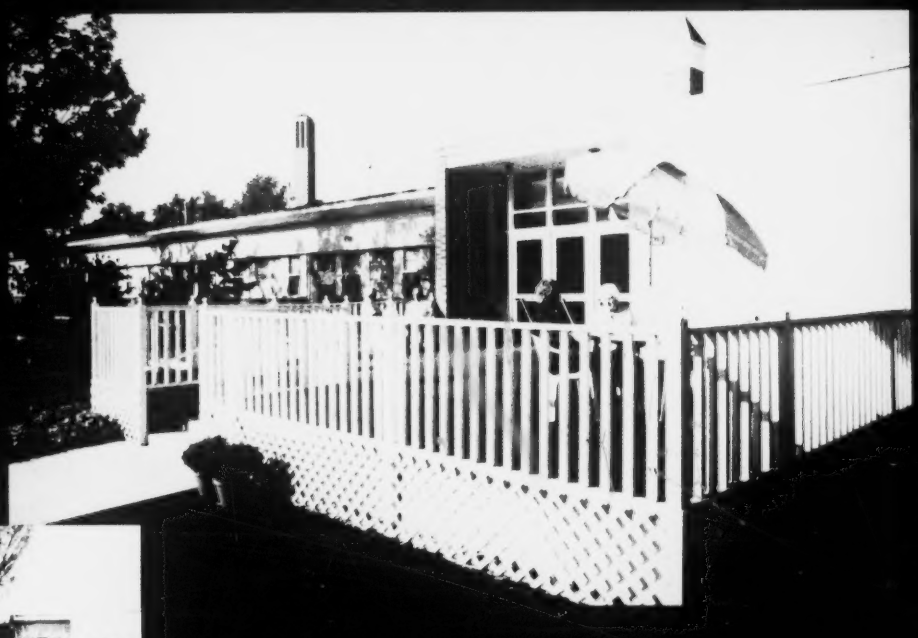
	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
ENTIRE U.S.	96.0%	100.0%	96.3%
SIZE:			
Under 150 Units	91.1	100.0	95.5
150 Units & Over	96.7	98.6	96.5
AGE:			
Built Before 1975	96.3	98.7	96.5
Built 1975-1984	97.9	100.0	95.5
Built 1985 & Later	66.1	**	94.9

*All amounts are medians.

EXHIBIT II-20: Type of Health Care Contract

In response to consumer demand, many forms of payment for health care have been developed. These range from all-inclusive to entirely pay-as-needed arrangements. The following definitions apply to Exhibit II-20: CONTINUING CARE COVERAGE—All inclusive for nursing care services. Monthly payment remains the same except for normal operating costs and inflation. Typically drugs, medical supplies and physician services are extra. LIMITED NURSING COVERAGE—Nursing care services are provided either up to a specified dollar amount, for a certain number of days or some combination of these. No nursing coverage. PRIORITY ADMISSION ARRANGEMENTS—Nursing care services are not covered by contract. Arrangements have been made for care, sometimes at a discounted rate, at either an on-site or off-site nursing home. Usually involves priority admission. NO NURSING COVERAGE—All nursing services are the responsibility of the resident and are paid at charges, either at an on-site or off-site facility. OTHER ARRANGEMENTS—Any type of nursing care contract not included above.

TYPE OF CONTRACT	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
Continuing Care Coverage	41.0%	29.6%	7.8%
Limited Nursing Coverage	21.3	14.8	7.8
No Nursing Coverage (Priority Admissions)	19.7	7.4	15.6
No Nursing Coverage	14.8	44.4	59.4
Other	3.2	3.8	9.4



Photos: Henderson Group Architects

Picture yourself in fourth grade, sitting in a large classroom, the wide corridor outside the door and the gymnasium down the hall. And now 20 years later, your mother is living in that school. Difficult to imagine? Not for the residents of DeSmet Apartments, formerly known as DeSmet Elementary School.

In 1986, the Brookview Group, a St. Louis development company, wanted to build apartments for the elderly. They targeted Florissant, a town with a burgeoning senior population. The problem was finding a large parcel of land in this densely populated area and obtaining zoning. DeSmet School was on the market for two years.

DeSmet Apartment Community
Florissant, Missouri

The developer's proposal for single-story construction and low density (16 units per acre) made multi-family zoning relatively easy to obtain.

The Brookview Group and Henderson Group, the architectural firm for the project, transformed the austere school into a friendly community. "Ten-foot wide school corridors are retained. Apartments are arranged with all entrances on the corridor, making the corridor the neighborhood street," said Paul Henderson, president of Henderson Group. "Lounges are placed at intervals along the 'streets' to provide casual meeting places. The converted cafeteria/gymnasium becomes the town center."

Barry Pessin, partner in the Brookview Group, said a major challenge to the conversion was the unknown cost of retrofitting a 1950s school. And part of that cost was due to asbestos. "It kept showing up where the contractor did not expect it, however the $20,000 price tag for removal was not a proportionally large expense," said Pessin.

A gymnasium became a recreation/dining area at neglible cost. Windows were replaced, shutters and siding added, as well as porches and lounges.

The 80 units—a wing was added—are targeted at moderate-income residents (one-bedroom units rent for $475 and two-bedrooms go for $650). Residents added their own touches, such as replacing plastic "All's Well" signs that hang on their doorknobs with needlepoint replicas. Safety features include grab bars and emergency pull chains in the bathroom and near the bed.

DeSmet rented out within 30 days after construction was completed. The Brookview Group converted a second school and based on DeSmet's success, minimal changes were made to the design: countertops were enlarged to fit microwaves, coat closets added and half-bath in the two-bedrooms for double-occupant households.

CHAPTER III: ENTRANCE FEE AND RENTAL FACILITIES: OPERATIONS

*EXHIBIT III-1: Square Footage: Entire U.S.**

Given the greater number of units among Type IA principally retirement centers, it is not surprising that Type IA facilities tend to be larger, since additional space is needed for common and support areas. Type IA communities tend to have larger units than Type IB communities, which in turn tend to have larger units than Type II rental facilities.

	ENTIRE U.S.		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
TOTAL AREA OF:			
Independent Living Units	67,824 sq. ft.	159,880 sq. ft.	229,172 sq. ft.
Assisted Living Units	9,261	18,706	34,500
Nursing Center	15,874	23,060	36,014
Common & Support Areas	11,936	27,531	61,131
Total Square Footage	98,313	212,533	330,475
UNIT TYPES:			
Studio w/out kitchen	293	365	409
Studio	433	486	552
One-Bedroom	585	635	702
One-Bedroom Deluxe	743	800	903
Two-Bedroom	845	906	1,014
Two-Bedroom Deluxe	966	1,083	1,200
Three-Bedroom	1,198	1,436	1,798
Cottage/Duplex (One-Bedroom)	900	1,079	1,287
Cottage/Duplex (Two-Bedroom)	781	1,120	1,264
NURSING CARE ORIENTED FACILITIES:			
TOTAL AREA OF:			
Independent Living Units	41,213	75,699	196,594
Assisted Living Units	3,072	14,000	26,814
Nursing Center	24,000	34,513	60,624
Common & Support Areas	5,697	31,000	48,000
Total Square Footage	93,662	123,650	351,283
UNIT TYPES:			
Studio w/out kitchen	275	325	369
Studio	388	447	490
One-Bedroom	504	566	627
One-Bedroom Deluxe	572	700	906
Two-Bedroom	717	800	990
Two-Bedroom Deluxe	953	1,219	1,434
Three-Bedroom	925	1,305	1,377
Cottage/Duplex (One-Bedroom)	**	1,050	**
Cottage/Duplex (Two-Bedroom)	1,068	1,210	1,525
RENTAL FACILITIES:			
TOTAL AREA OF:			
Independent Living Units	11,440	40,220	85,000
Assisted Living Units	7,745	15,990	27,128
Nursing Center	9,913	21,784	32,872
Common & Support Areas	12,268	21,883	39,231
Total Square Footage	47,883	84,883	145,885
UNIT TYPES:			
Studio w/out kitchen	209	308	391
Studio	304	377	447
One-Bedroom	454	540	613
One-Bedroom Deluxe	525	618	775
Two-Bedroom	708	830	910
Two-Bedroom Deluxe	792	939	1,113
Three-Bedroom	**	1,597	**
Cottage/Duplex (One-Bedroom)	**	**	**
Cottage/Duplex (Two-Bedroom)	956	1,210	1,456

*Each item was individually tabulated and does not necessarily add to totals shown.
**Insufficient response.

*EXHIBIT III-2: Square Footage by Size and Age of Facility**

Similarities exist in the sizes of individual units between small and large facilities. Similarities are also apparent among unit sizes for those facilities built before 1975 and those built 1975-1984. Communities built 1985 and later offer much larger units, though in most cases the amount of common and support space has remained nearly constant.

	SIZE		AGE		
	Under 150 Units	150 Units & Over	Built Before 1975	Built 1975-1984	Built 1985 & Later
PRINCIPALLY RETIREMENT CENTERS:					
TOTAL AREA OF:					
Independent Living Units	65,804 sq. ft.	207,386 sq. ft.	162,439 sq. ft.	160,000 sq. ft.	124,425 sq. ft.
Assisted Living Units	16,870	20,000	15,832	20,000	23,936
Nursing Center	20,645	23,060	21,237	27,500	23,000
Common & Support Areas	16,900	44,900	19,056	49,896	24,500
Total Square Footage	98,313	275,741	230,269	212,881	191,033
UNIT TYPE:					
Studio w/out kitchen	375	352	360	362	**
Studio	490	482	450	482	517
One-Bedroom	620	642	649	597	650
One-Bedroom Deluxe	810	794	800	808	804
Two-Bedroom	882	939	904	878	950
Two-Bedroom Deluxe	1,062	1,100	1,047	1,085	1,198
Three-Bedroom	1,333	1,476	1,718	**	1,250
Cottage/Duplex (One-Bedroom)	1,100	1,046	850	986	1,194
Cottage/Duplex (Two-Bedroom)	**	1,200	1,100	1,200	1,300
NURSING CARE ORIENTED FACILITIES:					
TOTAL AREA OF:					
Independent Living Units	69,340	188,703	70,039	92,263	**
Assisted Living Units	14,000	10,656	6,821	14,000	**
Nursing Center	30,330	42,904	37,259	24,000	**
Common & Support Areas	33,775	31,000	18,334	33,775	**
Total Square Footage	119,274	282,752	119,274	170,258	175,289
UNIT TYPE:					
Studio w/out kitchen	**	325	**	**	**
Studio	480	436	413	456	**
One-Bedroom	588	546	556	576	735
One-Bedroom Deluxe	784	669	638	742	978
Two-Bedroom	960	790	742	847	**
Two-Bedroom Deluxe	1,412	1,008	1,150	1,172	**
Three-Bedroom	**	1,309	**	1,309	**
Cottage/Duplex (One-Bedroom)	**	**	**	1,056	**
Cottage/Duplex (Two-Bedroom)	1,300	1,122	1,210	1,187	**
RENTAL FACILITIES:					
TOTAL AREA OF:					
Independent Living Units	30,000	112,760	41,220	40,110	30,000
Assisted Living Units	15,000	22,000	15,378	13,056	16,980
Nursing Center	16,980	24,708	31,000	13,634	28,565
Common & Support Areas	20,000	24,742	20,700	20,160	27,776
Total Square Footage	77,092	164,685	80,633	80,000	124,358
UNIT TYPE:					
Studio w/out kitchen	285	424	279	285	400
Studio	365	398	327	353	418
One-Bedroom	535	550	525	509	594
One-Bedroom Deluxe	593	631	736	585	753
Two Bedroom	790	862	745	780	869
Two-Bedroom Deluxe	865	1,018	1,000	845	995
Three-Bedroom	**	1,597	1,606	1,588	**
Cottage/Duplex (One-Bedroom)	**	**	**	**	**
Cottage/Duplex (Two-Bedroom)	1,300	1,200	1,220	**	**

*All amounts are medians. Each item was individually tabulated and does not necessarily add to totals shown.
**Insufficient response.

EXHIBIT III-3: Use of Space: Common and Support Areas

Use of space by retirement communities varies for many reasons, including local market factors that affect consumer preferences. Included in Exhibit III-3 is an analysis of facilities with certain uses of space and the square footage allotted to those areas.

USE OF SPACE	PRINCIPALLY RETIREMENT CENTERS		NURSING CARE ORIENTED FACILITIES		RENTAL FACILITIES	
	With Use/Space	Median Square Footage	With Use/Space	Median Square Footage	With Use/Space	Median Square Footage
Administrative Offices	100.0%	900 sq. ft.	100.0%	1,084 sq. ft.	100.0%	878 sq. ft.
Arts & Crafts	84.2	600	96.0	600	74.7	475
Auditorium/All-Purpose Room	77.2	2,657	80.0	2,692	67.5	1,490
Bank/Automatic Teller	35.1	375	40.0	291	13.3	120
Beauty/Barber Shop	93.0	300	92.0	349	83.1	253
Billiard Room	66.7	462	60.0	540	59.0	364
Card Room	47.4	660	32.0	697	51.8	400
Central Kitchen	96.5	2,000	96.0	1,759	92.8	1,436
Chapel	56.1	670	64.0	1,000	38.6	415
Conference Room	50.9	307	68.0	529	32.5	250
Convenience Store	36.8	384	48.0	250	25.1	300
Doctor's Office	42.1	150	60.0	300	18.1	250
Employee Lounge	73.7	304	88.0	450	49.4	270
Gift Shop	38.6	393	56.0	250	32.5	150
Guest Accommodations	77.2	758	64.0	1,380	51.8	550
Laundry/Linen	73.7	713	92.0	1,300	79.5	450
Library	94.7	420	84.0	460	85.5	368
Lobby	87.7	956	88.0	500	78.3	600
Lounge(s)	80.1	1,388	80.0	1,845	71.1	1,469
Main Dining Room	98.3	3,000	100.0	3,240	91.6	2,500
Meeting Rooms	71.9%	650	72.0	768	45.8	372
Music Room	47.5%	686	20.0	817	19.3	504
Nurse's Office	82.5	450	92.0	300	53.0	240
Personal Laundry	77.2	606	92.0	504	72.3	245
Pharmacy	17.5	265	12.0	**	6.0	**
Private Dining Room	63.2	300	52.0	733	34.9	300
Reception	84.2	245	76.0	400	69.9	450
Sewing Room	35.1	225	52.0	163	22.9	200
Snack Bar/Coffee Shop	28.1	450	28.0	447	24.1	281
Storage Space (Residents)	70.2	2,128	80.0	2,245	60.2	987
Woodworking Shop	57.9	300	56.0	607	25.3	300

**Insufficient response.

EXHIBIT III-4: Special Amenities and Services

Special services and amenities vary, particularly according to the facility's location. For example, facilities in warmer climates offer more outdoor activities. Physical programs and activities continue to play an important role in most retirement communities.

AMENITY OR SERVICE	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
Barbecue Area	39.3%	46.4%	36.0%
Cable Television	76.7	80.0	67.8
Catering Services	75.0	52.0	41.4
Delivery Services	61.7	56.0	39.1
Exercise Course	23.0	32.1	19.1
Exercise Programs	88.3	96.0	86.2
Fishing Pier	13.1	25.0	10.1
Fitness Center	42.6	35.7	27.0
Gardening Area	78.7	71.4	59.6
Golf Course	3.3	7.1	3.4
Horseshoes	31.1	21.4	28.1
Indoor Pool	13.1	14.3	4.5
Lake/Pond	26.2	46.3	27.0
Lawn Bowling	6.6	14.3	12.4
Master TV Antennae	63.3	60.0	55.2
Outdoor Pool	26.2	0.0	11.2
Picnic Pavilion	31.1	28.6	28.1
Pitch and Putt	14.8	7.1	5.6
Religious Service	88.3	96.0	79.3
Resident Association	93.3	84.0	77.0
Sauna	9.8	14.3	4.5
Shuffleboard	54.1	60.7	48.3
Tray Service	90.0	84.0	79.3
Tennis Courts	9.8	10.7	3.4
Walking Paths	68.9	75.0	73.0
Whirlpool	34.4	53.6	33.7

EXHIBIT III-5: Nursing Center Bed Analysis

According to this study's definition, Type IB nursing care oriented facilities have fewer than two apartments per nursing bed. Exhibit III-5 provides further explanation of the difference between facilities. As has been true in the past, several state regulations specify that retirement communities build nursing beds in the ratio of four apartments per bed. The median among Type IA principally retirement communities reflects this regulation. Type II rental facilities with nursing beds exhibit a trend similar to Type IB facilities.

	ENTIRE U.S.			SIZE*		AGE*		
	Lower Quartile	Median	Upper Quartile	Under 150 Units	150 Units & Over	Built Before 1975	Built 1975-1984	Built 1985 & Later
PRINCIPALLY RETIREMENT CENTERS:								
Number of Beds per Facility	40.3	60.0	73.8	40.0	60.0	58.0	60.0	57.5
Number of Apartment Units per Bed	2.7	3.6	4.5	2.8	3.6	3.6	2.9	3.2
NURSING CARE ORIENTED FACILITIES:								
Number of Beds per Facility	73.0	120.0	206.5	78.5	194.0	120.0	120.0	90.0
Number of Apartment Units per Bed	0.6	1.1	1.5	0.9	1.1	0.9	1.1	0.4
RENTAL FACILITIES:								
Number of Beds per Facility	57.0	88.0	120.0	63.0	93.0	101.0	57.0	118.5
Number of Apartment Units per Bed	0.4	1.1	2.1	0.5	2.1	0.7	2.1	1.0

*All amounts are medians.

EXHIBIT III-6: Gender of Residents

In general, females outnumber males in all types of retirement communities, except those restricted to men. This reflects the longer life span among women. Managers of retirement communities must be sensitive to the social needs of the "male minority," either through special men's nights or the provision of common areas such as woodshops or billiard rooms.

	MEAN		RANGE	
	Female	Male	Female	Male
PRINCIPALLY RETIREMENT CENTERS:				
1988	74.3%	25.7%	63.6-95.5%	4.5-36.4%
1987	76.4	23.6	64.1-94.6	5.4-35.9
1986	76.7	23.3	62.8-95.0	5.0-37.2
NURSING CARE ORIENTED FACILITIES:				
1988	74.1%	25.9%	60.0-97.3%	2.7-40.0%
1987	76.4	23.6	61.5-98.5	1.5-38.5
1986	76.5	23.5	62.2-97.1	2.7-37.8
RENTAL FACILITIES:				
1988	77.2%	22.8%	61.9-91.9%	8.1-38.1%
1987	76.7	23.3	62.0-92.0	8.0-38.0
1986	76.5	23.5	64.2-94.1	5.9-35.8

*EXHIBIT III-7: Average Age of Residents**

Despite attempts by marketers to appeal to "adults over 55," retirement communities are still largely populated by adults in their seventies and eighties. Consistent with the results of previous studies, the average age at entry is nearly 80. The average age of all residents tends to be greater for older facilities. This "aging in place" presents particular challenges for marketers seeking to attract younger residents to the facilities.

	AVERAGE AGE AT ENTRY TO APARTMENTS DURING THE LAST THREE YEARS		AVERAGE AGE OF ALL RESIDENTS 1988	
	Female	Male	Female	Male
PRINCIPALLY RETIREMENT CENTERS:				
Entire U.S.	78.0	78.4	81.0	80.8
AGE:				
Built Before 1975	78.9	78.4	82.0	81.5
Built 1975-1984	77.3	78.0	81.0	81.0
Built 1985 & Later	78.0	79.0	79.2	80.0
NURSING CARE ORIENTED FACILITIES:				
Entire U.S.	78.0	79.0	81.0	81.0
AGE:				
Built Before 1975	78.5	78.8	83.6	81.5
Built 1975-1984	78.0	79.0	80.0	80.8
Built 1985 & Later	76.5	78.0	79.3	80.3
RENTAL FACILITIES:				
Entire U.S.	80.0	79.0	82.0	81.0
AGE:				
Built Before 1975	80.5	79.0	82.0	80.5
Built 1975-1984	81.0	80.0	83.0	82.0
Built 1985 & Later	79.0	80.0	79.0	80.0

*All amounts are medians.

*EXHIBIT III-8: Entrance Fee Facilities: Annual Resident Turnover per 100 Residents by Age of Facility**

Exhibit III-8 reports the rates of deaths, permanent transfers to nursing facilities and voluntary withdrawal for all respondent facilities. The experience of all facilities was aggregated. Turnover rates are reported per 100 residents for both males and females. For example, in 1988 for every 100 female residents of Type IA principally retirement communities built before 1975, 13.2 left for all reasons. Of 100 male residents, 14.8 left the facility.

While aggregating the data provides a guidepost for facilities, the experiences at individual facilities may vary significantly.

	DEATHS		PERMANENT TRANSFERS TO NURSING		PERMANENT TRANSFERS TO PERSONAL CARE/ASSISTED LIVING		VOLUNTARY WITHDRAWAL		TOTAL TURNOVER	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
PRINCIPALLY RETIREMENT CENTERS:										
BUILT BEFORE 1975										
1988	4.7	8.4	5.4	4.3	2.1	1.3	1.0	0.8	13.2	14.8
1987	5.3	7.2	4.5	3.9	3.8	3.4	0.6	2.0	14.2	16.5
1986	5.1	8.6	4.8	5.8	2.8	1.3	1.0	1.1	13.7	19.8
BUILT 1975-1984										
1988	3.9	7.3	4.3	4.5	1.9	1.5	0.4	1.0	10.5	14.3
1987	3.6	7.3	4.3	5.3	2.6	1.7	0.5	1.2	11.0	15.5
1986	4.0	8.2	4.6	4.1	1.4	1.6	0.5	0.3	10.5	14.2
BUILT 1985 & LATER										
1988	3.9	9.3	3.7	3.7	1.2	1.4	1.7	2.4	10.5	16.8
1987	4.8	8.1	2.6	3.4	0.3	0.0	2.2	4.2	9.9	15.7
1986	**	**	**	**	**	**	**	**	**	**
NURSING CARE ORIENTED FACILITIES:										
BUILT BEFORE 1975										
1988	5.7	11.2	5.1	7.9	3.9	5.8	1.4	0.0	16.1	27.9
1987	5.8	9.7	6.6	8.5	4.1	13.5	0.3	0.3	16.8	32.0
1986	6.7	10.1	7.2	9.7	3.9	7.6	0.5	0.3	18.3	27.4
BUILT 1975-1984										
1988	3.6	9.1	3.3	5.0	3.1	1.3	1.8	1.1	11.8	16.5
1987	2.3	10.3	4.8	7.9	1.6	1.7	1.0	1.4	9.7	21.3
1986	4.7	6.4	4.9	6.6	1.1	0.8	1.3	0.7	12.0	14.5
BUILT 1985 & LATER										
1988	**	**	**	**	**	**	**	**	**	**
1987	**	**	**	**	**	**	**	**	**	**
1986	**	**	**	**	**	**	**	**	**	**

*All amounts are means.
**Insufficient response.

*EXHIBIT III-9: Rental Facilities: Annual Resident Turnover per 100 Residents by Age of Facility**

Exhibit III-9 presents data similar to Exhibit III-8 for Type II rental facilities. As is true with entrance fee facilities, males have higher turnover rates than females, primarily due to increased death rates among males.

	DEATHS		PERMANENT TRANSFERS TO NURSING CENTER		PERMANENT TRANSFERS TO PERSONAL CARE/ ASSISTED LIVING		VOLUNTARY WITHDRAWAL		TOTAL TURNOVER	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
RENTAL FACILITIES:										
Built Before 1975										
1988	3.6	7.3	4.3	5.3	2.6	1.7	0.5	1.2	11.0	15.5
1987	4.6	8.2	4.6	4.1	1.4	1.6	6.5	0.3	10.5	14.2
1986	3.5	8.2	4.1	5.1	0.3	0.4	3.1	5.2	11.0	18.9
Built 1975-1984										
1988	3.6	9.1	3.3	5.0	3.1	1.3	1.8	1.1	16.1	27.9
1987	5.7	11.2	5.1	7.9	3.9	8.8	1.4	0.6	16.8	28.0
1986	5.8	9.7	6.6	8.5	4.1	8.5	0.3	0.3	18.3	27.5
Built 1985 & Later										
1988	5.2	7.2	4.5	3.9	3.8	3.4	0.6	2.0	14.1	16.5
1987	5.1	9.9	4.8	5.8	2.8	4.3	1.0	1.1	13.7	21.1
1986	**	**	**	**	**	**	**	**	**	**

*All amounts are means.
**Insufficient response.

*EXHIBIT III-10: Entrance Fee Facilities: Annual Unit Turnover per 100 Independent Living Units by Age of Facility**

Unit turnover interests retirement housing managers because some units are occupied by married couples and death or transfer of a spouse does not necessarily mean unit turnover.

Consistent with results of previous years, older facilities tend to have higher turnover rates due to death and transfer to nursing care. These statistics are also aggregated for all respondents.

	DEATHS Units	PERMANENT TRANSFERS TO NURSING CENTER Units	PERMANENT TRANSFERS TO PERSONAL CARE/ ASSISTED LIVING Units	VOLUNTARY WITHDRAWAL Units	TOTAL TURNOVER Units
PRINCIPALLY RETIREMENT CENTERS:					
BUILT BEFORE 1975	4.5	4.4	2.4	1.5	12.7
1988	4.2	3.3	2.5	1.3	11.3
1987	4.5	3.5	1.2	1.2	10.5
1986					
BUILT 1975-1984					
1988	2.4	3.5	0.3	2.2	8.4
1987	1.6	3.2	0.1	1.5	6.4
1986	2.4	2.4	0.1	1.6	6.5
BUILT 1985 & LATER					
1988	2.1	1.5	0.6	1.1	5.3
1987	1.2	1.5	0.2	1.2	4.1
1986	**	**	**	**	**
NURSING CARE ORIENTED FACILITIES:					
BUILT BEFORE 1975					
1988	5.0	8.6	1.7	0.6	15.9
1987	5.8	7.8	1.7	0.5	15.8
1986	5.7	7.9	1.6	1.1	16.3
BUILT 1975-1984					
1988	6.4	5.5	1.7	0.4	14.0
1987	4.0	4.0	0.0	2.4	10.4
1986	2.3	7.2	0.1	0.8	10.4
BUILT 1985 & LATER					
1988	**	**	**	**	**
1987	**	**	**	**	**
1986	**	**	**	**	**

*All amounts are means.
**Insufficient response.

*EXHIBIT III-11: Rental Facilities: Annual Unit Turnover per 100 Independent Living Units by Age of Facility**

Exhibit III-11 presents the annual unit turnover for Type II rental facilities. Though reasons for withdrawal may vary from year to year, most facilities in the survey reported results that were consistent over time. This predictability allows administrators to estimate unit turnover and its impact upon revenue, marketing and maintenance costs.

	DEATHS	PERMANENT TRANSFERS TO NURSING CENTER	PERMANENT TRANSFERS TO PERSONAL CARE/ASSISTED LIVING	VOLUNTARY WITHDRAWAL	TOTAL TURNOVER
	Units	Units	Units	Units	Units
RENTAL FACILITIES:					
BUILT BEFORE 1975					
1988	3.4	4.0	0.3	2.1	9.8
1987	2.6	3.7	0.1	1.4	7.8
1986	2.4	2.4	0.1	1.6	6.5
BUILT 1975-1984					
1988	4.3	4.4	2.3	1.5	12.5
1987	4.1	4.3	2.4	1.3	12.1
1986	4.5	3.5	1.1	1.1	10.2
BUILT 1985 & LATER					
1988	2.6	3.7	0.1	1.4	7.8
1987	**	**	**	**	**
1986	**	**	**	**	**

*All amounts are means.
**Insufficient response.

*EXHIBIT III-12: Nursing Center Patient Days**

The figures presented in Exhibit III-12 reflect the number of patients in the nursing center on a particular day. For example, 32 nursing home patients were residents that had been permanently transferred from independent living units built before 1975. To estimate the annual patient days for each type of patient, multiply the number in the table by 365.

Facilities built after 1985 may have not yet constructed a nursing center; hence, the lower reported utilization of nursing beds by residents of independent living units. Recognizing this timing difference, some newer facilities opt to contract for nursing care with local facilities and complete construction of the nursing homes beds in the later phase of the project.

	PRINCIPALLY RETIREMENT CENTERS			NURSING CARE ORIENTED FACILITIES			RENTAL FACILITIES		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
TEMPORARY:									
Built Before 1975	1.5	4.8	6.8	1.0	1.6	3.8	1.4	5.2	9.8
Built 1975-1984	4.3	9.4	12.6	1.1	1.4	2.7	1.2	4.1	7.6
Built 1985 & Later	1.2	4.2	10.1	**	**	**	**	**	**
PERMANENT:									
Built Before 1975	28.2	31.9	44.5	3.8	51.6	89.7	7.8	21.2	48.1
Built 1975-1984	32.5	37.6	52.6	6.2	38.4	58.0	10.1	25.2	58.6
Built 1985 & Later	**	**	**	**	**	**	**	**	**
INDIVIDUALS FROM OUTSIDE:									
Built Before 1975	11.3	21.2	36.5	12.1	18.1	44.5	3.6	40.2	70.8
Built 1975-1984	7.9	14.5	27.1	17.4	27.6	55.7	6.8	16.2	68.7
Built 1985 & Later	**	**	**	**	**	**	**	**	**
TOTAL PATIENT DAYS:									
Built Before 1975	22.5	39.3	50.4	21.0	55.2	151.7	27.8	71.5	90.4
Built 1975-1984	48.6	57.1	84.2	54.5	67.0	162.8	41.6	60.1	87.2
Built 1985 & Later	**	**	**	**	**	**	**	**	**

*Each item was individually tabulated and does not necessarily add to totals shown.
**Insufficient response.

Vicar's Landing doesn't look like a traditional lifecare facility. With courtyards, a clubhouse, dining room, post office, chapel and bank, the community is a mini neighborhood where residents lead active, independent lives.

"Vicar's Landing has a residential character rather than an institutional one," said David Laffitte, vice president of KBJ, the Jacksonville, Florida architectural firm that designed the facility. "It blends an English village with a country club. All of the activity is in one area, so residents cross paths and meet each other regularly. Plus, all of the traffic is

Vicar's Landing
Ponte Vedra Beach, Florida

kept to the facility's perimenters, reinforcing the neighborhood concept."

Nine apartment buildings are grouped around courtyards; some buildings have two floors, others, three. All have wood siding, an architectural element carried throughout Vicar's surrounding community, Sawgrass. What's especially striking about the facility is the clubhouse. Pitches and gables accentuate its roofline; inside, a high, cupola-style ceiling overlooks the central entryway.

Owned by Life Care Pastoral Services, Inc., Vicar's Landing offers 229 apartments, a 30-bed skilled nursing facility and a 30-bed assisted living unit. Residents pay an entry fee ranging from $98,000 to $260,000 for a one- to three-bedroom apartment and a monthly fee, anywhere from $961 to $1,979. The facility is 90 percent sold and 80 percent occupied.

The facility also has an impressive interior. Minnesota-based Arthur Shuster Inc. designed the clubhouse and health care facilities, mirroring Sawgrass' elegance and affluence. Richard Wood, senior vice president of Arthur Shuster, said residents were intricately involved in the design process.

"We didn't design Vicar's Landing in a laboratory," said Wood. "We visited residents' homes, talked with them and found out what they liked and disliked. Then we proceeded."

Although Dan Dickenson, executive director of the facility, praises Vicar's design, he said he would change one thing. "With a facility like ours, internal transportation can be a problem for those people who are frail and can't walk too far. But the aesthetic value more than offsets that."

And anyway, they have a solution to the problem—the trusty, old golf cart.

EXHIBIT III-13: Entrance Fees by Selected Criteria: Entrance Fee Facilities

Entrance fees are based upon a variety of factors including unit size, age of facility, refundability, project construction costs, type of health care services offered, geographic location, amenities, and services and programs.

Exhibit III-18 presents the effects of some of these characteristics on entrance fees for one-bedroom units.

Entrance fees tend to be higher at newer and larger facilities. The median increase in entrance fees was 5 percent for Type IA principally retirement communities and 6 percent for Type IB nursing care oriented facilities.

	STUDIO W/OUT KITCHEN			STUDIO			ONE BEDROOM			ONE BEDROOM DELUXE		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:												
Entire U.S.	$10,250	$17,250	$29,575	$24,000	$35,650	$57,750	$35,500	$52,000	$ 72,800	$47,975	$73,500	$ 91,625
LOCATION:												
Urban	**	17,775	**	19,125	28,712	35,912	35,612	50,000	67,950	41,687	56,666	91,000
Suburban	**	20,750	**	23,250	37,500	57,750	33,000	52,000	69,406	59,150	77,687	104,000
Rural	**	11,687	**	11,650	44,100	70,600	38,875	58,750	94,981	45,000	75,950	92,500
AGE:												
Built Before 1975	**	17,775	**	13,000	25,000	31,865	31,612	38,250	54,166	21,875	52,233	70,770
Built 1975-1984	**	30,225	**	27,825	37,500	61,375	36,025	52,650	75,950	48,800	82,627	93,630
Built 1985 & Later	**	**	**	13,113	53,200	85,450	52,900	79,750	108,750	62,488	85,888	124,200
SIZE:												
Under 150 Units	**	19,650	**	10,250	26,050	60,087	33,412	41,750	73,250	41,687	64,000	90,400
150 Units & Over	**	17,000	**	25,666	36,000	58,000	38,000	55,600	72,800	48,575	75,950	92,750
NURSING CARE ORIENTED FACILITIES:												
Entire U.S.	**	23,500	**	23,000	39,500	44,000	29,750	47,500	61,287	**	70,225	**
LOCATION:												
Urban	**	**	**	**	**	**	**	**	**	**	**	**
Suburban	**	20,000	**	23,000	31,000	39,505	32,250	49,700	63,458	**	73,750	**
Rural	**	23,500	**	**	34,700	**	**	45,000	**	**	66,750	**
AGE:												
Built Before 1975	**	20,800	**	**	39,505	**	28,250	41,000	56,000	**	63,000	**
Built 1975-1984	**	**	**	**	35,250	**	32,250	49,700	59,050	**	69,950	**
Built 1985 & Later	**	**	**	**	**	**	**	73,700	**	**	89,200	**
SIZE:												
Under 150 Units	**	**	**	**	30,000	**	29,000	41,000	60,375	**	78,500	**
150 Units & Over	**	36,000	**	27,125	40,802	45,425	30,000	55,450	61,288	**	66,475	**

**Insufficient response.

TWO-BEDROOM			TWO-BEDROOM DELUXE			THREE-BEDROOM			COTTAGE-DUPLEX: ONE-BEDROOM	COTTAGE-DUPLEX TWO-BEDROOM
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Median	Median
$45,650	$ 71,200	$ 98,281	$55,775	$ 91,050	$132,000	$65,000	$110,000	$181,250	$87,900	$ 87,900
45,350	56,666	76,000	51,250	76,750	120,967	**	65,300	**	67,500	45,250
45,000	72,000	98,500	52,750	103,000	153,323	**	110,000	**	63,750	51,000
47,750	70,500	118,063	61,750	93,400	133,500	**	131,950	**	**	97,950
45,000	50,000	72,000	24,750	58,100	85,000	**	65,300	**	47,000	51,000
45,250	71,225	99,725	64,700	92,100	135,000	**	181,250	**	**	87,500
66,025	100,100	137,125	80,350	104,975	137,981	**	**	**	76,725	105,500
45,000	56,000	71,250	51,250	67,500	118,975	**	65,100	**	47,000	71,000
53,166	79,550	103,606	65,312	102,183	137,981	**	155,225	**	76,725	101,725
44,025	55,000	85,206	57,688	95,500	126,100	**	82,000	**	50,750	65,000
**	**	**	**	**	**	**	**	**	**	**
42,250	76,200	98,500	**	103,800	**	**	89,550	**	50,375	71,250
**	50,000	**	**	**	**	**	**	**	**	**
47,200	49,000	67,750	**	**	**	**	**	**	**	76,000
42,250	76,200	86,350	**	82,175	**	**	60,000	**	50,000	65,000
**	**	**	**	**	**	**	**	**	**	**
**	48,000	**	**	129,500	**	**	**	**	**	65,500
44,025	73,700	85,206	**	86,750	**	**	82,000	**	64,000	76,750

EXHIBIT III-14: Monthly Fees by Selected Criteria: Entrance Fee Facilities

Monthly fees vary considerably. One reason is differences in the service package—type of meal service, frequency of meals, housekeeping and transportation services, inclusion of utilities and the amount of health care included in the monthly fee. Labor costs also affect monthly service fees.

Among Type IA principally retirement centers, those built after 1985 consistently charge higher monthly fees. Monthly fees for entrance facilities rose a median 5 percent during the past year; this annual increase has remained consistent for the past three years.

	STUDIO W/OUT KITCHEN			STUDIO			ONE-BEDROOM			ONE BEDROOM DELUXE		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:												
Entire U.S.	$587	$734	$845	$575	$736	$ 992	$644	$ 908	$1,075	$670	$1,000	$1,340
LOCATION:												
Urban	**	682	**	536	673	737	674	816	1,017	751	955	1,245
Suburban	**	774	**	538	756	880	622	883	1,050	674	1,007	1,406
Rural	**	609	**	644	925	1,171	556	1,034	1,269	567	975	1,420
AGE:												
Built Before 1975	587	734	827	485	700	881	621	904	1,039	649	829	1,327
Built 1975-1984	**	640	**	574	660	904	622	761	1,051	599	876	1,353
Built 1985 & Later	**	**	**	663	904	1,240	800	1,050	1,344	734	1,171	1,445
SIZE:												
Under 150 Units	**	744	**	692	832	973	763	1,007	1,104	620	950	1,587
150 Units & Over	**	690	**	539	695	1,010	635	804	1,043	689	1,028	1,327
NURSING CARE ORIENTED FACILITIES:												
Entire U.S.	**	878	**	583	760	988	620	895	1,115	919	1,060	1,470
LOCATION:												
Urban	**	**	**	**	600	**	**	711	**	**	**	**
Suburban	**	**	**	**	700	**	475	840	995	**	1,000	**
Rural	**	877	**	**	902	**	**	1,098	**	**	1,120	**
AGE:												
Built Before 1975	**	878	**	**	789	**	818	990	1,115	**	1,143	**
Built 1975-1984	**	**	**	**	720	**	441	695	1,297	**	1,209	**
Built 1985 & Later	**	**	**	**	**	**	**	746	**	**	830	**
SIZE:												
Under 150 Units	**	**	**	**	820	**	630	868	994	**	960	**
150 Units & Over	**	933	**	**	700	**	620	910	1,358	**	1,293	**

**Insufficient response.

TWO-BEDROOM			TWO-BEDROOM DELUXE			THREE BEDROOM			COTTAGE DUPLEX: ONE BEDROOM	COTTAGE DUPLEX TWO-BEDROOM
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Median	Median
$766	$1,023	$1,439	$ 894	$1,150	$1,782	$1,042	$1,328	$1,900	$1,092	$ 977
733	956	1,247	970	1,256	1,397	**	1,200	**	1,095	**
766	959	1,318	903	1,242	1,847	**	1,185	**	1,090	782
743	1,402	1,588	756	1,145	1,907	**	1,600	**	**	1,007
716	870	1,401	812	900	1,850	**	1,339	**	1,095	977
735	956	1,250	779	1,160	1,557	**	1,920	**	**	635
968	1,361	1,748	1,071	1,499	1,966	**	**	**	1,186	1,224
901	1,325	1,588	910	1,150	1,787	**	**	**	1,095	**
744	954	1,319	842	1,169	1,690	1,006	1,328	1,915	1,090	1,007
843	1,070	1,385	700	1,200	1,918	**	778	**	**	462
**	925	**	**	**	**	**	**	**	**	**
576	1,125	1,437	**	1,422	**	**	995	**	**	510
**	1,100	**	**	**	**	**	**	**	**	**
983	1,015	1,384	**	1,293	**	**	**	**	**	793
**	998	**	**	712	**	**	**	**	**	415
**	**	**	**	**	**	**	**	**	**	**
991	1,125	1,296	**	1,225	**	**	**	**	**	462
743	980	1,592	**	1,050	**	**	**	**	**	497

EXHIBIT III-15: Monthly Rents by Selected Criteria: Rental Facilities

Generally, monthly rents are higher for rental facilities than for entrance fee facilities (Exhibit III-14). The monthly rent must cover operating costs, as well as any debt incurred with the building's construction. While consistent trends were not noted, newer and larger facilities tend to charge higher monthly rents. This trend is similar to entrance fee facilities. The median increase in rents among respondent facilities was 5 percent.

	STUDIO W/OUT KITCHEN			STUDIO			ONE BEDROOM			ONE BEDROOM DELUXE		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
RENTAL FACILITIES:												
Entire U.S.	$624	$845	$ 970	$424	$778	$ 985	$535	$ 945	$1,185	$574	$1,046	$1,380
LOCATION:												
Urban	720	834	899	623	858	1,012	740	745	1,155	573	1,022	1,480
Suburban	598	855	1,152	442	795	1,050	570	1,000	1,214	467	1,311	1,770
Rural	581	850	1,133	391	540	775	327	865	1,230	570	950	1,230
AGE:												
Built Before 1975	600	822	950	210	318	698	286	454	948	400	605	1,322
Built 1975-1984	707	810	1,191	751	870	985	820	1,033	1,275	870	1,073	1,280
Built 1985 & Later	**	875	**	623	936	1,083	750	1,100	1,345	607	1,495	1,870
SIZE:												
Under 150 Units	693	822	950	600	795	1,042	571	945	1,214	568	950	1,395
150 Units & Over	560	873	1,207	256	700	865	390	865	1,100	579	1,150	1,439

**Insufficient response.

TWO BEDROOM			TWO BEDROOM DELUXE			THREE BEDROOM			COTTAGE DUPLEX: ONE BEDROOM	COTTAGE DUPLEX TWO BEDROOM
Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Median	Median
$605	$1,013	$1,581	$ 724	$1,008	$1,480	**	$1,760	**	$1,300	$1,603
675	1,147	1,568	758	1,250	1,494	**	1,688	**	1,300	1,573
630	1,245	1,691	533	1,084	1,484	**	1,135	**	**	1,402
425	660	1,375	**	1,005	**	**	**	**	**	**
333	481	909	495	908	1,450	**	908	**	**	1,402
995	1,320	1,795	**	1,133	**	**	**	**	**	**
722	1,250	1,812	709	1,250	1,495	**	**	**	1,750	1,645
600	965	1,540	635	945	1,245	**	**	**	**	1,500
650	1,250	1,646	1,031	1,495	1,700	**	2,115	**	1,296	1,903

EXHIBIT III-16: Nursing Center Daily Rates

Nursing center rates reflect actual charges for the facility before any discounts for retirement community residents are applied. Median increases in nursing center rates were 6.5 percent for Type IA principally retirement centers, 8.0 percent for Type IB nursing care oriented facilities and 6.5 percent for Type II rental facilities.

	AVERAGE DAILY RATE		
	Lower Quartile	Median	Upper Quartile
PRINCIPALLY RETIREMENT CENTERS:			
Skilled Care Private Bed	$80.00	$89.50	$120.00
Skilled Care Semi-Private Bed	71.00	77.47	87.25
Intermediate Care Private Bed	64.70	85.00	110.00
Intermediate Care Semi-Private Bed	53.50	57.72	84.50
Personal Care (Sheltered) Private Bed	**	71.00	**
Personal Care (Sheltered) Semi-Private Bed	**	**	**
NURSING CARE ORIENTED FACILITIES:			
Skilled Care Private Bed	77.00	95.00	121.50
Skilled Care Semi-Private Bed	69.25	78.00	92.50
Intermediate Care Private Bed	63.00	80.00	109.00
Intermediate Care Semi-Private Bed	53.00	67.50	86.50
Personal Care (Sheltered) Private Bed	47.00	56.00	67.75
Personal Care (Sheltered) Semi-Private Bed	**	47.50	**
RENTAL FACILITIES:			
Skilled Care Private Bed	75.00	85.00	100.00
Skilled Care Semi-Private Bed	69.00	80.00	86.00
Intermediate Care Private Bed	62.00	78.00	127.50
Intermediate Care Semi-Private Bed	53.00	71.00	80.00
Personal Care (Sheltered) Private Bed	**	**	**
Personal Care (Sheltered) Semi-Private Bed	**	**	**

**Insufficient response.

*EXHIBIT III-17: Double Occupancy Percentage and Fees**

Consistency is the key in the fees charged for second occupants for all respondent facilities. As has been true in past surveys, married couples comprise the overwhelming majority of double-occupied units. However, double-occupied units remain only a small portion of total units.

TYPE OF UNIT	Occupied by More Than One Person	Married Couples: As Percent of Those Occupied by More Than One Person	Additional Monthly Fee for Second Occupant	Additional Entrance Fee for Second Person
PRINCIPALLY RETIREMENT CENTERS:				
Studio w/o Kitchen	2.6%	100.0%	$340	**
Studio	3.8	77.5	344	$ 7,500
One-Bedroom	10.5	100.0	327	8,810
One-Bedroom Deluxe	25.6	100.0	305	10,000
Two-Bedroom	39.4	100.0	318	10,000
Two-Bedroom Deluxe	50.1	95.7	350	10,000
Three Bedroom	66.7	96.8	288	**
Cottage/Duplex (One-Bedroom)	**	**	275	**
Cottage/Duplex (Two-Bedroom)	60.8	100.0	288	7,500
Total	19.8	98.7	N/A	N/A
NURSING CARE ORIENTED FACILITIES:				
Studio w/o Kitchen	**	**	**	**
Studio	5.4	100.0	326	4,500
One-Bedroom	6.8	100.0	305	5,000
One-Bedroom Deluxe	**	**	497	**
Two-Bedroom	35.8	97.6	430	5,000
Two-Bedroom Deluxe	51.5	98.4	305	**
Three Bedroom	**	**	**	**
Cottage/Duplex (One-Bedroom)	**	**	**	**
Cottage/Duplex (Two-Bedroom)	**	**	**	**
Total	18.4	98.5	N/A	N/A
RENTAL FACILITIES:				
Studio w/o Kitchen	1.4	100.0	270	N/A
Studio	2.6	100.0	250	N/A
One-Bedroom	11.7	98.7	250	N/A
One-Bedroom Deluxe	25.8	94.5	250	N/A
Two-Bedroom	41.2	100.0	250	N/A
Two-Bedroom Deluxe	50.9	100.0	250	N/A
Three Bedroom	68.5	78.6	250	N/A
Cottage/Duplex (One-Bedroom)	**	**	**	N/A
Cottage/Duplex (Two-Bedroom)	**	**	**	N/A
Total	21.3	98.6	N/A	N/A

*All amounts are medians.
N/A-Not applicable.

*EXHIBIT III-18: Effect of Various Characteristics on Fees for One-Bedroom Units**

As described in Exhibits III-13, III-14 and III-15, fees charged by respondent facilities are affected by various factors. Exhibit III-18 provides further analysis of fees charged for one-bedroom units.

CHARACTERISTIC	PRINCIPALLY RETIREMENT CENTERS Monthly Fee	PRINCIPALLY RETIREMENT CENTERS Entrance Fee	NURSING CARE ORIENTED FACILITIES Monthly Fee	NURSING CARE ORIENTED FACILITIES Entrance Fee	RENTAL FACILITIES Monthly Rent
MEAL PLAN:					
None	$655	$38,400	$548	$23,849	$672
One Meal Daily	741	51,725	652	47,687	861
Three Meals Daily	876	63,311	875	50,000	975
SQUARE FOOTAGE OF UNIT:					
Less than 600 Sq. Ft.	822	42,495	649	31,087	585
600 Sq. Ft. or More	825	65,875	851	47,439	969
HEALTH CARE SERVICES:					
No Nursing Coverage	485	31,459	541	24,555	621
Continuing Care Coverage	521	45,257	777	51,622	844
Limited Nursing Coverage	845	57,891	765	49,111	972
HOUSEKEEPING SERVICES:					
Not Provided	521	49,121	645	24,900	729
Provided	675	57,845	841	48,000	951

*All amounts are medians.

EXHIBIT III-19: Entrance Fee Refundability

When retirement housing was originally developed, entrance fees were generally unrefundable and were used to offset nursing care expenses, hence the term "lifecare." Now, numerous variations exist, and facilities may or may not provide nursing care. Exhibit III-19 depicts refunding options.

	PRINCIPALLY RETIREMENT CENTERS Upon Voluntary Withdrawal	PRINCIPALLY RETIREMENT CENTERS Upon Death	NURSING CARE ORIENTED FACILITIES Upon Voluntary Withdrawal	NURSING CARE ORIENTED FACILITIES Upon Death
No Refund*	10.8%	20.0%	5.6%	5.9%
Fully Refundable	10.8	11.4	11.1	17.7
Partially Refundable on Declining Scale	67.6	54.3	50.0	41.2
Other Refundability	10.8	14.3	33.0	35.2

*Except during trial period.

EXHIBIT III-20: Provision of Health Care Services

Many alternatives exist among retirement housing communities with respect to providing health care. An analysis of the services is presented here. Perhaps in response to actuarial studies of their health care liabilities, nearly twenty percent of Type IA principally retirement centers are planning to offer long-term care insurance.

HEALTH CARE SERVICES	PRINCIPALLY RETIREMENT CENTERS				NURSING CARE ORIENTED FACILITIES				RENTAL FACILITIES			
	Do Not Offer	Plan to Offer	Currently Offer	Offer At Charge	Do Not Offer	Plan to Offer	Currently Offer	Offer At Charge	Do Not Offer	Plan to Offer	Currently Offer	Offer At Charge
Skilled Nursing Care	29.1%	5.5%	34.6%	30.8%	23.1%	3.9%	30.8%	42.2%	75.7%	1.4%	4.3%	18.6%
Assisted Living Units	34.0	15.1	20.8	30.1	23.1	15.4	19.2	42.3	38.9	20.8	15.3	25.0
Priority Admission to Off Site Skilled Nursing	80.4	2.0	9.8	7.8	79.2	0.0	12.5	8.3	78.6	2.9	10.0	8.5
Priority Admission to Off Site Assisted Living	96.2	0.0	1.9	1.9	87.5	0.0	0.0	12.5	92.4	3.0	1.5	3.1
Transfer Agreement/Priority Admission w/Hospital	57.7	3.9	28.9	9.5	44.0	4.0	32.0	20.0	73.1	6.0	13.4	7.5
Long Term Care Insurance	76.9	19.2	3.9	0.0	84.0	4.9	4.0	8.0	82.1	14.9	1.5	1.5
Assistance with Activities of Daily Living	29.6	3.7	20.4	46.3	34.6	7.7	34.6	23.1	45.7	10.0	15.7	28.6
Home Health Care Program	48.1	7.7	13.5	30.7	44.0	12.0	12.0	32.0	70.0	8.6	4.3	17.1
Homemaker Services	49.1	1.9	9.4	39.6	51.9	14.8	14.8	18.5	70.0	7.1	4.3	18.6
Wellness Program	29.6	9.3	51.9	9.2	7.4	11.1	59.3	22.2	37.1	8.6	41.4	12.9
Physical Therapy	20.4	5.6	13.0	61.0	7.4	7.4	7.4	77.8	68.2	3.0	3.0	25.8
Occupational Therapy	37.7	5.7	7.6	49.0	34.6	3.9	7.7	53.8	76.9	1.5	0.0	21.6
Dental Care	50.0	5.6	3.7	40.7	30.8	3.9	0.0	65.3	74.6	0.0	0.0	25.4
Podiatrist	33.3	1.9	3.7	61.1	20.0	4.0	0.0	76.0	44.6	1.4	4.1	49.9
Prescription Drugs	50.0	0.0	7.4	52.6	14.8	7.4	3.7	74.1	62.3	0.0	0.0	37.7
Speech Therapy	35.2	3.7	9.3	51.8	33.3	3.7	3.7	59.3	76.9	0.0	1.5	21.6

EXHIBIT III-21: Principally Retirement Centers: Salaries

POSITION	1987			1988		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
ADMINISTRATION:						
Executive Director or Administrator	$38,500	$42,892	$56,875	$39,948	$50,000	$61,500
Assistant Administrator	25,000	28,164	35,000	27,619	30,500	39,500
Secretary	11,351	14,492	16,450	13,791	15,835	18,000
Receptionist	9,445	11,410	12,883	10,065	11,973	12,978
Clerical	**	11,474	**	**	**	**
FINANCE:						
Controller	26,325	30,803	38,587	27,000	31,550	36,708
Billing Clerk	10,400	12,373	16,000	12,524	14,000	17,052
Office Manager	**	19,500	**	**	20,604	**
SECURITY:						
Director	**	**	**	**	16,295	**
Staff	8,125	9,690	11,333	8,938	10,794	13,731
HOUSEKEEPING:						
Director	14,339	16,779	17,875	15,234	17,750	18,400
Housekeeper	8,883	9,483	10,620	8,920	9,984	12,000
Laundry Linen	**	10,667	**	**	10,710	**
MAINTENANCE:						
Director	22,027	24,428	27,698	23,745	27,000	30,000
Skilled	13,125	14,519	12,174	13,644	15,760	18,500
Unskilled	**	12,690	**	11,475	13,226	15,230
DIETARY:						
Director	19,882	25,064	26,517	20,147	24,522	29,850
Cook/Chef	**	13,000	**	**	13,026	**
Staff	**	9,366	**	**	9,354	**
Dietician	**	13,100	**	**	15,843	**
MARKETING:						
Director	**	26,683	**	22,175	26,551	34,620
Staff	**	17,908	**	**	23,034	**
ACTIVITIES:						
Director	14,363	17,408	19,793	15,000	18,592	21,780
Assistant	**	11,000	**	**	13,346	**
Staff	**	9,693	**	**	10,787	**
Vehicle Driver	**	12,581	**	**	11,875	**
OTHER SUPPORT:						
Chaplain	**	20,990	**	**	22,227	**
Human Resources	**	21,101	**	**	22,110	**
ASSISTED LIVING UNITS:						
Unit Director	**	**	**	**	15,600	**
RN	**	**	**	**	19,750	**
LPN	**	19,500	**	**	17,000	**
Aide	**	11,139	**	**	10,497	**
Ward Clerk	**	**	**	**	**	**
NURSING CENTER:						
Administrator	**	30,000	**	**	36,475	**
Director of Nursing	23,024	26,500	29,000	25,000	28,300	31,980
RN	18,264	21,000	22,669	20,000	22,858	25,390
LPN	13,590	14,777	17,602	14,279	16,137	18,888
Aide	9,626	10,894	12,568	10,075	11,937	14,581
Ward Clerk	8,701	12,032	14,375	**	12,260	**

**Insufficient response.

*EXHIBIT III-22: Nursing Care Oriented and Rental Facilities: Salaries**

POSITION	NURSING CARE ORIENTED FACILITIES		RENTAL FACILITIES	
	1987	1988	1987	1988
ADMINISTRATION:				
Executive Director or Administrator	$41,731	$43,689	$34,000	$35,000
Assistant Administrator	28,000	31,750	**	18,000
Secretary	16,750	16,800	14,600	13,220
Receptionist	9,708	11,247	11,086	10,400
Clerical	**	**	**	**
FINANCE:				
Controller	30,171	32,259	**	31,836
Billing Clerk	13,989	15,000	12,678	12,854
Office Manager	17,000	18,720	17,308	19,707
SECURITY:				
Director	**	15,369	**	**
Staff	**	10,380	9,873	10,272
HOUSEKEEPING:				
Director	16,756	16,526	15,342	15,606
Housekeeper	16,333	10,892	9,455	9,881
Laundry/Linen	11,341	9,880	10,153	11,036
MAINTENANCE:				
Director	25,058	25,000	20,050	20,000
Skilled	15,295	14,917	15,968	14,973
Unskilled	9,686	10,150	10,200	11,720
DIETARY:				
Director	19,000	17,000	18,840	18,720
Cook/Chef	12,380	12,675	11,482	12,022
Staff	9,070	9,753	10,324	9,901
Dietician	**	**	**	11,003
MARKETING:				
Director	**	**	25,085	24,500
Staff	**	**	22,042	**
ACTIVITIES:				
Director	14,400	15,528	15,865	15,315
Assistant	12,850	13,500	**	14,501
Staff	10,820	10,994	**	10,252
Vehicle Driver	**	**	11,440	10,500
OTHER SUPPORT:				
Chaplain	18,616	20,856	**	**
Human Resources	**	**	**	**
ASSISTED LIVING UNITS:				
Unit Director	**	25,961	25,388	21,628
RN	22,406	24,603	**	22,411
LPN	**	17,294	**	18,500
Aide	10,400	10,900	16,134	10,244
Ward Clerk	**	**	**	**
NURSING CENTER:				
Administrator	**	**	**	39,300
Director of Nursing	25,288	25,000	27,778	28,627
RN	22,116	22,590	19,644	22,297
LPN	15,847	16,142	16,883	17,051
Aide	10,526	10,320	11,793	10,754
Ward Clerk	10,500	11,600	**	11,198

*All amounts are medians.
**Insufficient response.

EXHIBIT III-23: Full-Time Equivalents by Facility Type

POSITION	PRINCIPALLY RETIREMENT CENTERS			NURSING CARE ORIENTED FACILITIES			RENTAL FACILITIES		
ADMINISTRATION:	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
Executive Director or Administrator	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Assistant Administrator	1.0	1.0	1.0	1.0	1.0	1.8	1.0	1.0	1.0
Secretary	1.0	1.0	1.0	1.0	1.0	2.0	1.0	1.0	1.0
Receptionist	1.0	2.4	3.5	1.0	2.0	3.8	1.0	1.0	2.8
Clerical & Other	1.0	1.5	3.8	1.0	1.0	2.0	1.0	1.0	1.0
FINANCE:									
Controller	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Billing Clerk	1.0	1.3	2.0	1.0	1.0	1.4	1.0	1.0	1.0
Office Manager	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
SECURITY:									
Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	2.0
Staff	2.0	3.2	6.0	2.3	4.1	7.3	1.5	3.0	4.0
HOUSEKEEPING:									
Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Housekeeper	6.1	11.0	14.0	6.3	8.5	13.9	2.0	4.0	8.0
Laundry/Linen	1.0	2.0	4.0	2.0	2.6	4.8	1.0	2.0	4.0
MAINTENANCE:									
Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Skilled	2.0	2.0	6.8	2.0	4.0	6.0	1.0	1.0	2.0
Unskilled	2.0	3.0	5.8	1.1	3.0	5.0	1.0	2.0	3.8
DIETARY:									
Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Cook/Chef	1.9	4.3	6.1	2.0	4.0	5.0	1.6	3.0	4.0
Staff	13.4	20.0	25.6	8.0	20.0	31.1	4.0	5.5	15.1
Dietician	1.0	1.0	1.0	1.0	1.0	1.0	0.5	2.0	7.4
MARKETING:									
Director	**	**	**	**	**	**	**	**	**
Staff	1.0	2.0	3.0	**	**	**	**	**	**
ACTIVITIES:									
Director	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Assistant	1.0	1.0	1.6	0.6	1.0	1.0	1.0	1.0	1.0
Staff	1.6	2.7	4.5	1.3	2.3	3.8	1.0	2.6	5.5
Vehicle Driver	1.0	1.1	1.8	1.0	1.0	1.0	1.0	1.0	1.0
OTHER SUPPORT:									
Chaplain	1.0	1.0	1.0	0.7	1.0	1.0	0.2	1.0	1.0
Human Resources	1.0	1.0	1.4	1.0	1.0	1.0	**	1.0	**
ASSISTED LIVING UNITS:									
Unit Director	1.0	1.0	1.0	**	1.0	**	1.0	1.0	1.0
RN	2.3	3.0	3.0	0.5	1.0	1.9	**	1.0	**
LPN	1.0	1.9	3.8	1.9	2.0	2.2	1.0	2.0	2.0
Aide	3.0	6.0	8.4	2.5	3.0	5.6	5.0	8.0	10.0
Ward Clerk	1.0	2.0	6.8	**	**	**	**	**	**
NURSING CENTER:									
Administrator	1.0	1.0	1.0	1.0	1.0	1.0	**	1.0	**
Director of Nursing	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
RN	3.3	5.0	7.8	3.0	7.5	9.8	2.0	3.0	7.0
LPN	3.0	5.0	8.0	5.0	7.0	9.5	3.5	6.0	22.0
Aide	10.5	21.8	29.7	21.5	36.0	44.8	12.5	21.0	53.8
Ward Clerk	1.0	1.3	3.8	1.0	1.5	2.3	**	1.0	**

**Insufficient response.

*EXHIBIT III-24: Dietary Expenses per Meal**

Dietary costs are affected by the manner in which meals are served, as well as by the type of food served. Type I principally retirement communities tend to have the highest dietary costs.

	Cafeteria Style	Restaurant Style	Family Style
PRINCIPALLY RETIREMENT CENTERS:			
Salaries & Wages	**	$2.19	$1.77
Raw Food Costs	**	1.74	1.91
Other Dietary Costs	**	.47	.30
Food Service Management Company	**	**	**
Total Cost per Meal	**	$4.48	$3.54
NURSING CARE ORIENTED FACILITIES:			
Salaries & Wages	**	$1.37	**
Raw Food Costs	**	1.31	**
Other Dietary Costs	**	.56	**
Food Service Management Company	**	**	**
Total Cost per Meal	**	$2.84	**
RENTAL FACILITIES:			
Salaries & Wages	1.75	1.59	1.09
Raw Food Costs	1.22	1.45	1.06
Other Dietary Costs	**	.22	.60
Food Service Management Company	**	**	**
Total Cost per Meal	$2.64	$3.53	$2.71

*All amounts are medians. Each item individually tabulated and does not necessarily add to totals shown.

EXHIBIT III-25: Dietary Department

Additional statistics regarding the dietary department are presented in Exhibit III-25. Serving meals restaurant style, e.g., from a menu, is the most popular option for all respondent facilities. Most facilities receive additional revenue from additional meals sold to residents, guests or employees.

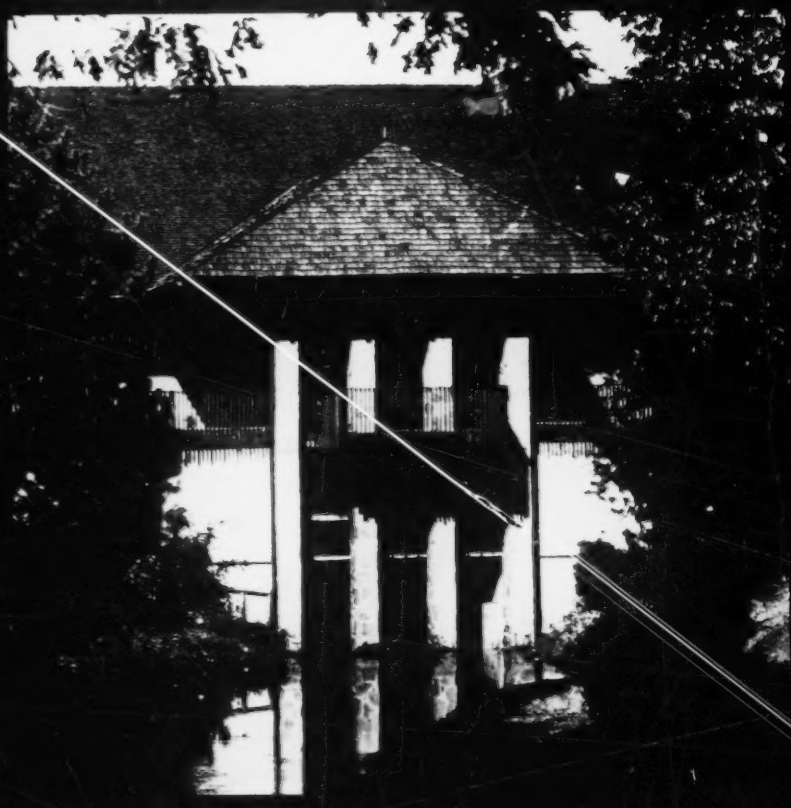
CHARACTERISTIC	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities
TYPE OF MEAL SERVICE:			
Cafeteria Style	7.0%	4.4%	12.1%
Restaurant Style	70.2	56.5	55.4
Family Style	10.5	13.0	14.5
Combination	12.3	26.1	13.3
Other	0.0	0.0	4.7
EMPLOYEE MEALS:			
Pay Full Charges	3.5%	0.0%	7.7%
Do Not Use Dietary Service	8.6	0.0	3.9
Free Meals	25.9	48.0	50.0
Pay Discounted Rate	55.2	36.0	30.8
Pay Cost	6.8	16.0	7.6
FOOD SERVICE REVENUE:*			
Additional Meals for Residents	$ 9,315	$ 8,269	$ 7,438
Employee Meals	6,780	7,148	2,536
Guest Meals	10,957	11,284	5,000
Private Dining Catering	2,917	7,891	1,000
Tray Service	2,572	650	600
Meals on Wheels	**	**	**
Other Revenue	20,262	8,415	**
Total Revenue	$37,710	$31,285	$16,000

*All amounts are medians. Each item individually tabulated and does not necessarily add to totals shown.
**Insufficient response.

EXHIBIT III-26: Various Expense Statistics

Various expense statistics at respondent facilities are presented in Exhibit III-26. Similarities exist between the facilities for many of these measures. Utility costs can vary widely, depending upon whether residents pay all or some of the utility costs for their apartments.

STATISTIC	PRINCIPALLY RETIREMENT CENTERS			NURSING CARE ORIENTED FACILITIES			RENTAL FACILITIES		
	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile	Lower Quartile	Median	Upper Quartile
HOUSEKEEPING:									
Payroll Expense Per Square Foot	$.35	$ .50	$ .78	$.45	$ .79	$1.09	$.23	$ .57	$1.46
Square Foot Per Housekeeper	13,663 sq. ft.	18,855 sq. ft.	24,284 sq. ft.	9,400 sq. ft.	13,965 sq. ft.	20,000 sq. ft.	10,899 sq. ft.	22,645 sq. ft.	32,297 sq. ft.
MAINTENANCE:									
Payroll Expense Per Square Foot	$.24	$ .47	$ .63	$.31	$ .53	$ .79	$.22	$ .41	$ .64
Square Foot Per Maintenance Employee	24,801 sq. ft.	31,336 sq. ft.	51,279 sq. ft.	22,560 sq. ft.	25,761 sq. ft.	41,603 sq. ft.	23,675 sq. ft.	42,383 sq. ft.	68,743 sq. ft.
UTILITIES (per square foot):									
Entire U.S.	$.81	$ .99	$1.21	$.80	$1.08	$1.28	$.81	$1.21	$1.67
Under 150 Units	.78	.98	1.24	.86	1.08	1.21	.77	1.12	1.70
150 Units or More	.81	1.00	1.21	.79	1.03	1.50	.81	1.39	1.69



Photographer: James Abbott

Most local residents can recall what used to stand on the site of Cadbury's health care facility: a Hawaiian restaurant with a pineapple motif. Adjacent was the Cherry Hill Lodge, a hotel in a thriving Philadelphia suburb filled with malls, shops and restaurants.

In the mid-1970s, however, the hotel's business was bust because of competition from nearby lodging facilities. Bankruptcy followed and a sale sign went up.

The timing was perfect, that is, for the Religious Society of Friends. According to Frank Gillett, Cadbury's administrator, the Quakers wanted to establish a

Cadbury Continuing Care Retirement Community
Cherry Hill, New Jersey

retirement center for moderate-income elderly who wanted to remain in the neighborhood. The problem: skyrocketing metro Philadelphia land costs. The solution: converting the Cherry Hill Lodge to a retirement center.

The hotel's design lent itself to a conversion that took only four months. The building's assets were many: a majestic lobby complete with an enormous stone fireplace, polished wood and chandeliers; dining rooms; banquet facilities; and most importantly, hotel rooms that became small units that moderate-income elderly could afford. In 1981, a fire destroyed the adjacent Hawaiian restaurant, and Cadbury purchased the land for a nursing center.

Although generally pleased with the conversion, regarding the rooms, Gillett said, "What was an asset became a drawback." With the elderly market turning away from small units, what happens when you have 70 percent studios? Knock down the walls and combine units, Cadbury's solution.

Occupancy hovers at 98 percent for the facility's 171 units and 120 health care beds. With prices the local market can afford (entrance fees starting at $36,000 and monthly fees from $900) and the area's aging population, Cadbury is poised for continued success. An expansion of 64 apartments is underway.

It's a facility that truly serves the local population's needs.

CHAPTER IV: ASSISTED LIVING UNITS/FACILITIES

Assisted living services continue to be a growing trend within the retirement housing industry. Many of this year's respondents are planning to add assisted living services (Exhibit III-20). Freestanding assisted living facilities are also being developed; information about freestanding units and units affiliated with retirement housing communities are presented in the following exhibits.

The median age of assisted living unit residents is 83 for females and 81 males. Thirty-two percent of the facilities reported maintaining a waiting list. The median rate increase was 5 percent for all facilities. An overwhelming majority of residents—92.3 percent—lived in the same state prior to admissions. Fifty-three percent of the residents had children living within a thirty-minute drive, and 31 percent had other relatives within that distance. These statistics support the theory that decisions to enter assisted living facilities tend to be need driven.

States vary in both their definition and regulation of assisted living services. For the purposes of this study, assisted living has been defined as the level of care between independent living and licensed nursing care. The amount of care provided can be subject to strict regulation in some states; in others it is not governed.

Typically all meals and full-service housekeeping are included in the monthly fee. The service package usually includes assistance with activities of daily living, such as bathing, dressing, eating, grooming and toileting and, in some states, administering medication. Administering medication, however, is problematic in many states. If the facility does more than remind residents to take medication, it becomes a licensed nursing home. Understanding the individual state regulations in assisted living is critical.

*EXHIBIT IV-1: Square Footage: Assisted Living Units**

Various types of units are offered to residents in respondent assisted living facilities. These units tend to be smaller than similar independent living units (Exhibit III-1 and III-2). Semi-private rooms are an option at some assisted living facilities.

TYPE OF UNIT	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities	Assisted Living Facilities
Semi-Private Room	**	250 sq. ft.	300 sq. ft.	260 sq. ft.
Private Room	300 sq. ft.	250	300	190
Studio w/Kitchen	419	**	410	300
One-Bedroom	554	**	502	420
Other	680	**	713	**

*All amounts are medians.
**Insufficient response.

EXHIBIT IV-2: Number of Assisted Living Units

Facilities dedicated to assisted living provide a greater number of assisted living units than retirement facilities offering assisted living. Usually retirement facilities provide assisted living services in a wing or portion of the nursing care center. Since Type IA principally retirement centers tend to be larger (Exhibit III-1), these facilities provide fewer assisted living beds per resident than do the other facilities.

TYPE OF FACILITY	ENTIRE U.S.		
	Lower Quartile	Median	Upper Quartile
Principally Retirement Centers	21.0	33.0	53.0
Nursing Care Oriented Facilities	19.0	37.5	94.3
Rental Facilities	22.0	32.0	45.0
Assisted Living Facilities	31.0	54.0	88.0

*EXHIBIT IV-3: Monthly Fees: Assisted Living Units**

Monthly fees tend to be higher in assisted living facilities than in independent living units (Exhibit III-14 and III-15). This is not surprising given the intensity of services provided to assisted living residents, including additional meals, housekeeping and assistance with activities of daily living.

TYPE OF UNIT	Principally Retirement Centers	Nursing Care Oriented Facilities	Rental Facilities	Assisted Living Facilities
Semi-Private Room	**	$ 950	$1,000	$ 900
Private Room	$1,375	1,256	1,360	1,274
Studio w/Kitchen	1,245	**	1,173	**
One-Bedroom	1,450	**	1,450	**
Other	1,283	**	**	**

*All amounts are medians.
**Insufficient response.

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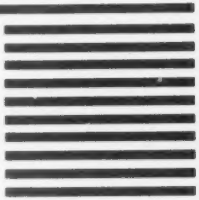

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